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Law, Theory, and Politics: The Dilemma of Soviet Psychiatry

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TABLE OF CONTENTS

| | PAGE |
|-------------------------------------------------------------------------------------------|------|
| INTRODUCTION | 298 |
| I. DETERMINISM AND RESPONSIBILITY: SOME PRELIMINARY ETHICAL CONSIDERATIONS | 301 |
| A. <i>Early Uses of Medicine to Repress Dissent</i> | 301 |
| B. <i>The Political Context of Therapy</i> | 304 |
| II. THE HISTORICAL AND THEORETICAL ROOTS OF MODERN SOVIET PSYCHIATRY | 306 |
| A. <i>Historical Roots</i> | 306 |
| B. <i>Theoretical Roots</i> | 307 |
| III. THE LEGAL FRAMEWORK FOR PSYCHIATRIC INTERNMENT OF SOVIET DISSIDENTS | 312 |
| A. <i>Krushchevian Reform</i> | 312 |
| B. <i>Criminal Commitment</i> | 316 |
| C. <i>Civil Commitment</i> | 327 |
| IV. DISSSENT AS DISEASE: THE EVOLUTION OF PYSCHIATRIC THEORY IN THE SOVIET UNION | 333 |
| A. <i>A Genetic Theory Emerges: The Snezhnevsky System</i> | 334 |
| B. <i>An Older Diagnostic Construct: Paranoid Psychopathy</i> | 346 |
| C. <i>Forensic Diagnosis and Value Premises</i> | 349 |
| V. IMPLICATIONS FOR INTERNATIONAL HUMAN RIGHTS ACTIVISM | 353 |
| A. <i>The Current Style of Activism: Confrontation and Castigation</i> | 353 |
| B. <i>Towards a New Activism</i> | 358 |

Law, Theory, and Politics: The Dilemma of Soviet Psychiatry

M. Gregg Bloche†

Introduction

It is today beyond genuine dispute that the Soviet authorities systematically intern dissenters in mental institutions. Through dissident sources, Amnesty International has learned in some detail of 305 cases of such internment between 1969 and 1983.¹ Other sources report more than 500 "well-authenticated cases" from 1962 through 1983.² The total number of interned dissenters, however, may actually be much higher. In 1981, a senior official in the Soviet Ministry of Health told a nationwide congress of psychiatrists that 1.2 percent of admissions at one Moscow mental institution were "in connection with visits to State agencies to present groundless complaints and slanderous statements."³ Based on estimates of the total number of patients in Soviet psychiatric hospitals, some have figured from this revelation that up to 6000 persons nationwide may be interned for acts of dissent.⁴

The types of dissent which have led to criminal and civil psychiatric internment in the Soviet Union may be divided into five categories: (1) expression of unauthorized ideological, social, or cultural views (these represent the largest proportion); (2) agitation for greater national rights

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1. AMNESTY INTERNATIONAL, POLITICAL ABUSE OF PSYCHIATRY IN THE U.S.S.R.: AN AMNESTY INTERNATIONAL BRIEFING 3-4 (1983) (120 cases in 1969-75, 100 cases in 1975-79, and 85 cases in 1979-83).

2. S. BLOCH & P. REDDAWAY, SOVIET PSYCHIATRIC ABUSE: THE SHADOW OVER WORLD PSYCHIATRY 30, 73 (1984). Similarly, Ludmilla Thorne, who tracks news from Soviet dissident movements for Freedom House, reported in late 1983 that she knew of 215 dissenters confined within psychiatric hospitals at that time. Thorne, *Philosophical Intoxications and Other Soviet Ailments*, FREEDOM AT ISSUE, Sept.-Oct. 1983, at 21.

3. INTERNATIONAL ASSOCIATION ON POLITICAL USE OF PSYCHIATRY [hereinafter IAPUP], INFORMATION BULL. NO. 2, Oct. 1981, at 10 (quoting from paper presented in May 1981 to 7th All-Union Congress of Psychiatrists and Neuropathologists).

4. See American Psychiatric Association, The International Response to Psychiatric Abuse (unpublished June 1984 memorandum) (on file with the *Yale Journal of International Law*).

and autonomy in education, language, and culture, as well as in political and economic administration (within this category Lithuanian and Ukrainian nationalists have been the most active); (3) requests or attempts to emigrate; (4) religious activism (Buddhist, Jewish, Baptist, and Pentecostalist); and (5) persistent pressing of complaints upon the authorities.⁵ Methods of activism that have precipitated internments include: making protests to officials in writing or in person; writing open letters; *samizdat* circulation of bulletins, journals, essays, or books; forming unapproved organizations; protest demonstrations (rare); and attempts to enter foreign embassies or cross Soviet borders.⁶

It also appears beyond dispute that a substantial proportion of dissidents who have been psychiatrically interned are, by Western standards, mentally healthy or only mildly disturbed and not in need of involuntary hospitalization. A number of one-time internees who later emigrated to the United States and Western Europe have been examined by Western clinicians and found free of diagnosable mental illness.⁷ In 1978, a prominent British psychiatrist on a private visit to the U.S.S.R. examined nine dissenters—including some former psychiatric internees—who feared future commitments. He reported that while four of the nine displayed evidence of mild psychopathology, he found no evidence justifying commitment.⁸ Moreover, two dissident Soviet psychiatrists, in coordination with the Moscow-based Working Commission to Investigate the Use of Psychiatry for Political Purposes, examined more than fifty dissenters between 1977 and 1981.⁹ Their evaluations, which were in accord with

5. S. BLOCH & P. REDDAWAY, *PSYCHIATRIC TERROR* 263-72 (1977).

6. *Id.*

7. Perhaps the leading case is that of Pyotr Grigorenko, a former Soviet army major general, whose criticism in the early 1960's of special privileges given to high Party officials began a career of dissent that led to two psychiatric hospitalizations and the loss of his high army rank. In 1964 and 1969, following his arrests, two forensic commissions from the Serbsky Institute for Forensic Psychiatry—the leading Soviet forensic center—diagnosed his case to involve paranoid psychopathy, complicated by cerebral arteriosclerosis, and found him criminally non-responsible. During a 1978 visit to his son in the United States, he was stripped of his citizenship by the Supreme Soviet and then granted asylum by the U.S. In 1979, he was examined by a team of well-known psychiatric, neurological, and psychological consultants from Columbia, Harvard, and Yale Universities. Applying conventional American criteria, these clinicians found him to be without a diagnosable mental disorder, although they did note "signs of mild depression," as well as some sensory and motor impairment, probably secondary to a 1972 stroke. Reich, *The Case of General Grigorenko*, *ENCOUNTER*, Apr. 1980, at 9.

8. S. BLOCH & P. REDDAWAY, *supra* note 2, at 137 (citing LOW-BEER, *REPORT TO THE ROYAL COLLEGE OF PSYCHIATRISTS* (1978)).

9. IAPUP, *INFORMATION BULL. NO. 1*, May 1981, at 13. The Working Commission, a panel of seven activists affiliated with the Moscow Helsinki Group, prepared more than 1500 pages of documentation on several hundred cases of internment during its four-year tenure. Founded in 1977, principally through the efforts of Alexander Podrabinek, the Commission investigated and reported in detail on legal and psychiatric treatment of dissidents. It also lobbied Soviet doctors and government officials, as well as foreign organizations, in an effort to

Western standards and won high praise from American and European psychiatric organizations,¹⁰ likewise discerned no psychopathology believed to justify either civil or criminal commitment.¹¹

The involuntary confinement of dissidents in mental institutions in the Soviet Union has produced an outpouring of criticism in the West.¹² It is a remarkable feature of this criticism, however, that it largely operates from an assumption of "simple evil." In essence, this view presumes that absolute, apolitical standards exist for the diagnosis of mental disorders justifying involuntary commitment, and that Soviet psychiatrists consciously and cynically breach these diagnostic and ethical principles by participating in the hospitalization of dissidents whom Western doctors would find mentally healthy. In this view, any claimed theoretical justification for such practices is mere pseudoscience and conscious fraud. Some adherents to this view acknowledge, with a nod to Thomas Szasz and psychiatry's other radical critics,¹³ that the process of diagnosis is "closely intertwined with social factors" and that there are "sometimes considerable differences among various cultures . . . in the clinical approach to [certain] patterns of behaviour"¹⁴ Yet instead of exploring the possibility that political dissent might be one such "pattern of behavior," they avoid this troubling question in favor of a simpler formulation: social and cultural differences render psychiatry vulnerable to "sinister" misuse for "non-medical" reasons, such that "patients lose paramountcy."¹⁵

In this Article, I will contend that the prevailing image of the Soviet psychiatrist as a soulless flunky or scheming thug, obedient to devious

marshal pressure against psychiatric internments. The psychiatrist Alexander Voloshanovich, a member of the Commission, prepared 41 evaluations of dissidents who feared psychiatric internment before he emigrated in 1978. Over the next three years, a successor, Dr. Anatoly Koryagin, performed 16 more evaluations. In 1980, as part of a broad crackdown on all dissident movements, the authorities began arresting the Commission's members. By mid-1981, all, including Koryagin, had been convicted and sentenced, and the Commission had been disbanded. *Id.* at 13-18; see also S. BLOCH & P. REDDAWAY, *supra* note 2, at 75-110.

10. See S. BLOCH & P. REDDAWAY, *supra* note 2, at 82, 149-53.

11. Dr. Alexander Voloshanovich, who performed most of the evaluations, see *supra* note 9, concluded that some of the examinees suffered from "apparent personality disorders" but that none needed compulsory hospitalization. See Voloshanovich, *Psychiatry in the USSR: An Insider's View from the Outside*, MED. & HUM. RTS.: BULL. OF AMNESTY INT'L BRIT. MED. GROUP, Feb. 1982, at 17-18.

12. See, e.g., AMNESTY INTERNATIONAL, *supra* note 1; S. BLOCH & P. REDDAWAY, *supra* note 5; H. FIRESIDE, SOVIET PSYCHOPRISONS (1979).

13. See T. SZASZ, THE MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT (1961); see also RADICAL PSYCHOLOGY (P. Brown ed. 1973).

14. S. BLOCH & P. REDDAWAY, *supra* note 2, at 13-14. The authors mention homosexuality and drug and alcohol use as examples.

15. *Id.* at 15.

KGB mentors, represents a grossly inadequate understanding of why dissenters are systematically interned in Soviet mental hospitals. More plausibly, I will argue, the typical Soviet clinician involved in such internments acts with no less sincere a belief in the clinical and ethical rightness of her actions than does an American counterpart in forensic work. Finally, I will suggest that the probability that Soviet psychiatrists act out of genuine commitment to a system of theory and ethics rooted in value preferences alien to the pluralist West has important implications for the strategies of Western human rights activists in international fora.

Part I will explore ethical dilemmas inherent in the practice of psychiatry in any society. Part II will discuss the historical and theoretical sources of modern Soviet psychiatry's political authority. Part III will consider how the mechanics of the Soviet legal system invite the suppression of dissent through involuntary psychiatric commitment. Part IV will analyze current Soviet psychiatric theories and their intrinsic political content; it will then explore how this content is expressed in forensic practice, resulting in involuntary commitment practices that are shockingly repressive by Western standards. Finally, Part V will discuss some implications of this analysis for international human rights activity aimed at Soviet psychiatric internment of dissidents. Only by better comprehending, and taking seriously, the value premises implicit in Soviet psychiatric theory and forensic practice can we sharpen our moral critique of what the Soviets do and heighten our insight into human rights problems that theories and technologies of the mind can pose for all societies.

I. Determinism and Responsibility: Some Preliminary Ethical Considerations

A. *Early Uses of Medicine to Repress Dissent*

Throughout most of the Europe of 1484, churchmen and freemen could sense an atmosphere of rising social tension and religious ferment. Thirty-three years were still to pass before a disconsolate Wittenberg cleric would nail to the doors of a castle chapel his shocking challenge to the Church's secular authority. Yet a rising class of tradesmen and merchants was already questioning scholastic views on worldly affairs, and a Renaissance ethos of emerging individualism was nurturing newly critical attitudes toward Church dogma.¹⁶ On December 9, 1484, Pope Innocent VIII moved decisively in response. The Papal Bull he issued

16. See R. TAWNEY, *RELIGION AND THE RISE OF CAPITALISM* 11-115 (1926).

noted "with the most heartfelt anxiety" and "bitter sorrow" that many "unmindful of their own salvation and straying from the Catholic Faith, have abandoned themselves to devils; incubi; and succubi" ¹⁷ An alarming rise in witchcraft was to blame for this "heretical depravity," and the Bull enjoined that an army of Inquisitors be empowered to search out and destroy its practitioners. ¹⁸

Although campaigns against witches had been waged irregularly for more than two centuries, the new Inquisition was at first stymied by a lack of systematic criteria for the mass identification of these challengers to faith and order. An enterprising pair of medically-inclined Dominican friars proposed a curious solution to this dilemma of applied theology. In a 1486 treatise, *Malleus Maleficarum*, they articulated a vision of witchcraft as a demonically-triggered medical illness, to be diagnosed by the careful scrutiny of clinical signs, symptoms, and diagnostic test results. Physicians, they contended, ought to be responsible for making the "diagnosis." Buttressed by clinical case reports ¹⁹ and complete with a theory of pathogenesis ²⁰ and a detailed discussion of symptoms, signs, ²¹ and useful diagnostic tests, ²² the Dominicans' approach struck a resonant pitch in a society largely committed to its faith, yet newly intrigued by critical rationality. Inquisitors throughout Europe rapidly embraced it. ²³

17. THE MALLEUS MALEFICARUM OF HEINRICH KRAMER AND JAMES SPRENGER xliii (M. Summers ed. 1971) [hereinafter cited as H. KRAMER & J. SPRENGER].

18. *Id.* at xliii-iv.

19. These Dominican friars marshalled case histories in support of numerous clinical principles. Thomas Szasz cites one example—the rule that sudden, dramatic onset of illness in one person is typically a product of another's witchcraft. "A certain well-born citizen of Spire," the Dominicans reported, had a wife of "obstinate disposition" who "refused in nearly every way to comply with his wishes." During a quarrel, the authors claimed, she "loudly swore that, unless he beat her, there was no honesty or faithfulness in him." He then

stretched out his hand, not intending to hurt her, and struck her lightly with his open palm on the buttock; whereupon he suddenly fell to the ground and lost all his sense, and lay in bed for many weeks afflicted with a most grievous illness. Now it was obvious that this was not a natural illness, but caused by some witchcraft of the woman.

T. SZASZ, THE MANUFACTURE OF MADNESS 8-9 (1970) (quoting H. KRAMER & J. SPRENGER, *supra* note 17, at 87).

20. "Carnal lust" was the root cause of all witchcraft; thus most witches were female because lust "is in women insatiable." H. KRAMER & J. SPRENGER, *supra* note 17, at 47.

21. Physical signs included such common dermatologic features as moles, scars, hemangiomas, and supernumerary nipples; all were regarded as "devil's privy marks," proof of a pact with Satan. T. SZASZ, *supra* note 19, at 32.

22. "Witch-pricking" was one such tool. Invisible "witch spots," bloodless and insensitive to pain, were believed to be proof of a pact with Satan. Physicians probed for such "spots" by inserting long needles into suspects' flesh, monitoring for bleeding and cries of pain. *Id.* at 33.

23. H. KRAMER & J. SPRENGER, *supra* note 17, at viii.

For the first time in history physicians were established in the role of "diagnosing" dissent against an established order.²⁴ At witch trials, medical testimony was decisive. And if a medieval physician felt troubled by any sense of conflict between his identity as a healer and his legal role in condemning "patients" to be burned alive, he could comfort himself with the authoritative reassurance of the *Malleus Maleficarum* that "whatever is done for the safety of the State is merciful."²⁵

The central role of physicians in the "diagnosis" of witchcraft during the twilight years of feudalism is troubling early evidence of the potential power of clinical classification as an instrument of social control.²⁶ Nor were the first clinicians to move beyond religious conceptions of madness to secular and materialist theories shy about urging medical explanations and treatment for political dissent. Dr. Benjamin Rush, a signer of the Declaration of Independence and generally acknowledged as the father of American psychiatry, claimed that colonists opposed to the rebellion against the Crown suffered from a mental sickness—"revolutiona"—for which the "cure" was simply to switch sides.²⁷ Rush explained the post-war spirit of hostility to creation of a strong central government as another illness—"a form of insanity which I shall take the liberty of distinguishing by the name of *anarchia*."²⁸

There is no evidence that such theories were used to suppress dissent. They illustrate, however, two themes central to the current debate over the alleged political abuses of the mental health professions: the use of

24. Challengers to theologic orthodoxy, particularly from those with an interest in scientific experimentation, were especially vulnerable to the "diagnosis" of witchcraft. See generally M. MURRAY, *THE WITCH-CULT IN WESTERN EUROPE* (1921); C. WILLIAMS, *WITCHCRAFT* (1941). The early psychiatrists, however, beginning with Benjamin Rush, reinterpreted witchcraft as mental illness. T. SZASZ, *supra* note 19, at 68-74. A leading historian of psychology, Gregory Zilboorg, has argued that the mass witch-hunts triggered by the Papal Bull of 1484 and the *Malleus Maleficarum* were motivated largely by the growing insecurity of feudal religious and secular authorities and that most accused witches were, in fact, mentally ill. See generally G. ZILBOORG & G. HENRY, *A HISTORY OF MEDICAL PSYCHOLOGY* (1941).

25. H. KRAMER & J. SPRENGER, *supra* note 17, at 231.

26. In the 16th century, during the height of the witch-hunting era, opposition to the diagnosis and burning of witches was weak and was itself considered a symptom of witchcraft. T. SZASZ, *supra* note 19, at 8. But 17th century clerics, physicians, and lawyers began to challenge the evidence and verdicts in witch trials, charging that such "signs" as privy marks, see *supra* note 21, were natural characteristics of most people; that confessions were frequently extracted by torture; and that evidence was often fraudulent. *Id.* at 32, 298-99. These early dissenters braved arrest and trial by Catholic and Protestant authorities, but by the mid-18th century the era of witch-hunts had been brought to an end by secular authorities despite lingering religious objections. *Id.* at 298-302. See generally R. ROBBINS, *THE ENCYCLOPEDIA OF WITCHCRAFT AND DEMONOLOGY* (1959).

27. D. BOORSTIN, *THE LOST WORLD OF THOMAS JEFFERSON* 182 (1948).

28. *Id.* at 182. The principle symptom was an "excess of the passion for liberty, inflamed by the successful issue of the war," leading to "opinions and conduct which could not be removed by reason" *Id.*

diagnosis to discredit the dissenter and her ideas, and the use of treatment aimed at the "cure" of recantation.

B. *The Political Context of Therapy*

Wherever clinicians have amassed considerable cultural authority²⁹ as arbiters of health and disease, medicine has been a significant source of social norms. This function of medicine is ultimately circular, however, for the clinicians' norms inevitably reflect those of their patrons. Whether a system of therapeutic thought is built on notions of science or of the supernatural, its clinical raw materials are the complaints and cues of those who seek assistance. These complaints and cues reflect a subjective sense of what is deviant and unpleasant, and thus fit for therapeutic action. Such is the case whether a complainant is worried about crushing chest pain, the shape of his nose, or a co-worker's ideas. The therapeutic agent imputes meaning to a complaint by measuring it against her sense of what is normal. This sense is shaped in large part by professional and life experiences—prior medical complaints and other social cues—which reflect cultural ideas about what is and is not sufficiently deviant and unpleasant to merit intervention. In virtually any modern society, the life-threatening nature of crushing chest pain will seem to deserve intervention. But the form of a complainant's nose, or of a co-worker's ideas, may or may not be so viewed, depending on the cultural context.

Thus, a society's clinicians could be considered as passive agents of deterministic cultural forces, rather than as willing social regulators. Yet surely this cannot be the complete story, for it would deprive the doer of any individual responsibility for her deed. Unless the precept of individual responsibility is to be preserved, it can make no sense to consider, as an international human rights issue, the political use of diagnostic and therapeutic approaches to mental illness. For otherwise any "abuse" would be merely the mechanistic consequence of a system of social norms comprehensible in value-free social science terms, without reference to individual rights or responsibility.³⁰

29. See P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982) (discussion of how physicians amass "cultural authority" over illness and health).

30. As Hannah Arendt has written,

We have become very much accustomed by modern psychology and sociology, not to speak of modern bureaucracy, to explaining away the responsibility of the doer for his deed in terms of this or that kind of determinism. Whether such seemingly deeper explanations of human actions are right or wrong is debatable. But what is not debatable is that no judicial procedure would be possible on the basis of them, and that the administration of justice, measured by such theories, is an extremely unmodern, not to say outmoded, institution.

H. ARENDT, *EICHMANN IN JERUSALEM* 289-90 (1964).

That, surely, would be determinism run amok. No society could permit its cherished beliefs that people have basic rights—civil and political, or social and economic—to be eviscerated by such a mechanistic explanation. Preservation of such beliefs, however, demands that value choices be made to delineate the deeds for which individuals ought to be held morally accountable, irrespective of the explanatory force of cultural or other determinism.

Human rights activists make such choices, either openly or implicitly, when they condemn the use of psychiatry as an instrument of political repression. The “simple evil” theory, however, implies that no such choices are necessary in order to condemn Soviet psychiatric diagnosis and internment of dissenters. Rather, the theory assumes that value-free, *clinical* criteria exist and make possible a neutral assessment of Soviet psychiatric practices. It has been urged, for example, that the correct “clinical meaning” of “socially dangerous” as a criterion for civil commitment is *physical* dangerousness to oneself or others.³¹ A commitment is clinically improper and thus a human rights violation, by this line of reasoning, if this “clinical meaning” is supplanted by a broader, politically-charged “judicial meaning” that “the patient was capable of harming the social system as a whole.”³² Indeed, a virtually unanimous international consensus holds that it is justifiable to deprive mentally disturbed persons of their liberty because of physical dangerousness to others or to themselves. Such unanimity represents agreement on *values*, however, and is thus no less intrinsically political—albeit less controversial—than the view that expression of ideas that challenge a social order is socially dangerous.

More broadly, political bias is inherent in the very concept of mental illness. All diagnostic and therapeutic activities have political impact.³³ To acknowledge this, one need not embrace the radical critique of the concept of mental illness as a repressive myth invented solely to suppress undesired behavior.³⁴ Anna Freud once complained: “Young people . . . see that what psychoanalysis may lead to is adaptation to society, and that is the last thing they have in mind.”³⁵ This biological vision of health as homeostasis implies a therapeutic technology which, like Augustinian theology, urges individuals to accept social structure as fate.³⁶

31. See, e.g., Koryagin, *Unwilling Patients*, LANCET 821, 822 (1981).

32. *Id.*

33. See, e.g., S. HALLECK, *THE POLITICS OF THERAPY* (1971).

34. See, e.g., T. SZASZ, *supra* note 13 (most prominent exposition of the radical critique).

35. N.Y. Times, Oct. 10, 1982, § 1, at 46, col. 1.

36. This is not necessarily all bad. As one believer in the homeostasis model has observed, its radical critics, such as Thomas Szasz and R. D. Laing, tend to discount the human anguish

The natural political effect of diagnosis and treatment is, under any social system, the nurturing of conservatism, whether or not this is the practitioners' conscious end.³⁷ Thus, if persons are to be held responsible for intending the natural consequences of their acts, everything mental health professionals do is political in intent.

To condemn the Soviet conceptualization of dissent as dangerous disease, while accepting the diagnosis and treatment of say-manic behavior, is to recognize some line between intolerable and acceptable political functions of psychiatry. Such a line cannot be discerned by logical deduction from neutral truth. It must be drawn via the assertion of preferred values. Human rights norms are nothing more than agreed-upon value preferences.³⁸ Thus, the attempt to draw such a line, when considering a given psychiatric practice, is a coherent human rights enterprise.

II. The Historical and Theoretical Roots of Modern Soviet Psychiatry

A. *Historical Roots*

Sidney Bloch and Peter Reddaway, who have written the most extensive account of the Soviet political use of psychiatry, trace Russian abuses back to the Pyotr Chaadayev affair of 1836. Chaadayev, a prominent philosopher, wrote a commentary critical of Tsar Nicholas I's regime and was promptly denounced by Nicholas himself for purveying "a farrago of insolent nonsense."³⁹ Nicholas, perhaps reluctant to appear crudely repressive after a recent relaxation of censorship,⁴⁰ responded with a curious gambit. Instead of "punishing" Chaadayev in a conventional sense, Nicholas declared that the philosopher deserved "sympathy," for he suffered from "derangement and insanity."⁴¹ "Taking into

so often associated with failure or unwillingness to adapt to one's social setting. G. VAILLANT, *ADAPTATION TO LIFE: HOW THE BEST AND THE BRIGHTEST CAME OF AGE* 362 (1977).

37. Thus, as Vaillant observes, Thoreau and Gandhi would have scored poorly in the leading prospective psychiatric study of life adjustment. *Id.* at 358. "If you have not the strength to accept the terms life offers you," Vaillant pronounces, "you must, in self-defense, force your own terms upon it. If either you or your environment is distorted too much in the process, your effort at adaptation may be labeled mental illness." *Id.* at 13.

38. See generally M. McDUGAL, H. LASSWELL & L. CHEN, *HUMAN RIGHTS AND WORLD PUBLIC ORDER* (1980) (attempt to build a theory of human rights out of "widely shared" values).

39. S. BLOCH & P. REDDAWAY, *supra* note 5, at 48.

40. Chodoff, "1984": *Utopias, Dystopias, and Psychiatry*, 12 J. AM. ACAD. PSYCHOANALYSIS 459, 462 (1984).

41. S. BLOCH & P. REDDAWAY, *supra* note 5, at 48 (quoting Z. MEDVEDEV & R. MEDVEDEV, *A QUESTION OF MADNESS* 196-97 (1971)).

consideration the unwell state of this unfortunate person," the Tsar announced, "the government in its solicitude and fatherly concern for its subject, forbids him to leave the house and will provide free medical care."⁴² The Tsar, as Bloch and Reddaway note, thereby not only put a troublesome dissident out of action, but also discredited the dissident's critique.⁴³

This medical approach to dissent was rarely employed during tsarist and early Bolshevik times.⁴⁴ Psychiatric internment of political personae non gratae did not become a regular practice until the Stalinist purges of the 1930's.⁴⁵ During the Stalinist era, moreover, psychiatrists' motives for committing dissidents may have been largely humanistic.⁴⁶ Conditions in mental hospitals were relatively mild compared with Stalinist penal camps. Ex-internees have reported that psychiatrists sought to use their diagnostic authority in order to spare the internees the brutalities of the Gulag.⁴⁷

B. *Theoretical Roots*

By the end of the Stalinist era, however, Soviet psychiatrists had developed an elaborate theoretical scheme to justify the forced hospitalization of dissidents. This scheme had roots in both the revolutionary optimism of the triumphant Bolsheviks and the traditional Russian propensity to view individuals' challenges to authority as something unnatural.⁴⁸ Upon assuming power, the Bolsheviks set out to marshal mental health professionals for a grand campaign to formulate a new science of the mind. Grounded in the dialectical materialism of Marx and Engels, the new mental science was to play a pivotal role in the creation of the New Soviet Man, wholly committed to communist values and unafflicted by individualistic, bourgeois psychic drives.⁴⁹ Crime and mental illness,

42. *Id.* Chaadeyev was detained at home for a year.

43. *Id.* at 49.

44. *Id.* at 49-51.

45. *Id.* at 51-58.

46. *Id.* at 53 (citing a former internee). Bloch and Reddaway report that information on psychiatric internment during the Stalinist era is scanty. *Id.* at 51.

47. *Id.* at 53. After an inspection tour of the Serbsky Institute for Forensic Psychiatry, a 1948 Party commission complained that the internees' regime was not severe enough and that too many were ruled not responsible. *Id.* at 53-54 (quoting a former internee). See also M. Field, Commitment for Commitment: The Soviet Psychiatric Shunt 2 (unpublished paper prepared for Fifth Int'l Conference on Social Science and Medicine, 1977) (cited with permission of the author) (copy on file with the *Yale Journal of International Law*).

48. See H. SETON-WATSON, *THE DECLINE OF IMPERIAL RUSSIA* 22-24 (1952). See also *infra* notes 305-09 and accompanying text.

49. See R. WOODWORTH & M. SHEEHAN, *CONTEMPORARY SCHOOLS OF PSYCHOLOGY* 90-94 (1964); Galach'yan, *Soviet Psychiatry*, in *PSYCHIATRY IN THE COMMUNIST WORLD* 29 (A. Kiev ed. 1968).

along with all other social problems, were to disappear with the elimination of class conflict and the achievement of pure communism.⁵⁰

Accordingly, Soviet psychiatrists rejected the Freudian conception of man as inexorably driven by instinctual needs.⁵¹ Not only were Freudianism's pessimistic implications an anathema to Soviet scientists determined to remake human nature, but psychoanalytic models of symptom formation were "blindly speculative, idealistic constructs" that ignored neurophysiological reality and thus had "nothing in common with the philosophic methodology of dialectical materialism."⁵² This methodology required a unity between the *conceptual* and the *material*—between the mental and the neurophysiological.⁵³

During the first few decades of Bolshevik rule, Soviet scientists struggled in vain to formulate such a synthesis. Several theorists were briefly embraced, appointed to high academic positions, and then sacked.⁵⁴ But a combination of classic scientific serendipity and aggressive intellectual entrepreneurship eventually produced a solution that the Party more permanently enshrined.

1. The Pavlovian Model

The story of Ivan Pavlov's accidental discovery of the conditioned reflex is a legend in biomedical science. The Soviet physiologist's studies of salivary secretions in dogs were stymied by a nagging problem: his technicians could not determine the baseline (fasting) secretion rate because salivation increased when they approached the animals to make measurements. Pavlov knew that the salivary reflex was triggered naturally by the stimulus of food on the tongue, and he noted that the technicians were also responsible for feeding the dogs. He theorized that an association between feeding and arrival of a technician *conditioned* a salivary response to the technician's arrival itself. His famous experiment, in which attendants rang a bell with each feeding and discovered that after several feedings the bell alone elicited the salivary reflex, confirmed his theory. More generally, he concluded, "a stimulus that originally did not elicit the response does so after having been repeatedly a part of the situation to which the response was made."⁵⁵ He carried the theory further, concluding that conditioning could also occur when the stimulus

50. Chodoff, *supra* note 40, at 463.

51. Galach'yan, *supra* note 49, at 39.

52. *Id.*

53. See R. WOODWORTH & M. SHEEHAN, *supra* note 49, at 90-91.

54. See *id.* at 91-94.

55. E. HEIDBREDER, SEVEN PSYCHOLOGIES 245 (1933).

remained the same but a new response was substituted, as when a child, instead of pointing to an object, learns to call it by name.⁵⁶

This model of learning, with its optimistic implication that natural stimulus-response connections could be remodeled without limit, became the foundation for a Soviet theory of mental life. Pavlov satisfied the requirements of dialectical materialism by linking this model with a putative neurophysiological mechanism.⁵⁷ He proposed boldly that association via the conditioned reflex was the basic element of all thought, knowledge, and insight.⁵⁸ His synthesis resonated with the Marxist-Leninist conception of consciousness as something present "only in socialized human beings" and something which "has evolved historically in dependence on man's labor and social organization [an amalgam of conditioned stimuli and responses]."⁵⁹ Soviet psychiatrists designed institutional regimens and approaches to individual patients based on this synthesis.⁶⁰ In 1950, Pavlov was "politically canonized" at a joint session of the Soviet Academies of Sciences and Medical Sciences which was dedicated to the exposition of orthodox Pavlovian principles and the criticism of deviations.⁶¹ By the close of the Stalinist era, Pavlovian approaches dominated the field, amidst soaring optimism that the new mental health technology could create neuronal pathways towards the communist transformation of man, ending crime, mental illness, and other social deviance.⁶²

56. *Id.*

57. Conditioning, Pavlov explained, involved the creation of new neuronal connections: Any unconditioned . . . stimulus undoubtedly evokes a state of nervous activity in some definite part of the brain. . . . During the period of excitation of such centers all other external stimuli which happen to affect the animal are conducted to these centers, and the paths by which they are conducted through the hemispheres become thereby specially marked out. This is the only possible interpretation of the facts.

R. WOODWORTH & M. SHEEHAN, *supra* note 49, at 96 (quoting Pavlov). Pavlov's investigations, though, afforded no direct test of this physiological hypothesis.

58. "I am fully convinced that thinking is association. . . . Association is knowledge, it is thinking, and when you make use of it, it is insight" *Id.* (quoting Pavlov).

59. *Id.* at 94.

60. See Galach'yan, *supra* note 49, at 38.

61. R. WOODWORTH & M. SHEEHAN, *supra* note 49, at 95.

62. In 1952, a Moscow bureaucrat reportedly boasted to the visiting Adlai Stevenson that schizophrenia had already been eradicated. Chodoff, *supra* note 40, at 463. Of course it had not been, but Soviet psychiatrists seem to have believed that in time, with Pavlovian techniques, it would be. This optimism had an ironic mirror-image in the West, where a post-Freudian generation of psychoanalysts asserted that an analytic approach could successfully treat some cases of schizophrenia and other psychoses, a claim that even Freud, who thought analysis could benefit only non-psychotic patients, would have rejected. See, e.g., H. ROSENFELD, *PSYCHOTIC STATES: A PSYCHO-ANALYTIC APPROACH* 127 (1965).

2. Political Implications

In three senses, Pavlovian doctrine encouraged the rise of what Westerners have viewed as the brutal misuse of psychiatry to quash political dissent. First, the principle that all knowledge, thought, and even insight is the sum of many elemental conditioned responses suggests an extraordinarily wide role for psychiatrists in the task of socialist construction, a task that according to Leninist thought requires the silencing of "reactionary," dissenting voices. Second, the Pavlovian conception of "treatment" as reconditioning—the creation of socially desirable neuronal pathways—undermines Western notions of a distinction between humane "therapy" and unethical "punishment." New responses can be conditioned with the help of aversive experiences as well as pleasant ones. Thus a Western human rights activist's "punishment" may be a Soviet psychiatrist's efficacious "therapy." Third, and perhaps most troubling for the liberal conscience, the Pavlovian model of the mind as a summation of conditioned responses renders the dissenter's moral claim to freedom meaningless.

Thus, Pavlovian theory lent substantial intellectual force to the development of a psychiatric approach to dissent, and was not, as the "simple evil" theorists assume, merely a cynical rationalization for totalitarian repression. This conclusion is supported by the political implications discerned by Western enthusiasts of Pavlov in the conditioned reflex paradigm.⁶³ The absence of a systematic psychiatric approach to politically

63. The intellectual journey of John B. Watson, America's leading Pavlovian, illustrates the Pavlovian model's power even outside the Marxist framework as a basis for the use of psychology to achieve political ends. Watson embraced the conditioned response as the basic building block of all thought, emotion, and behavior—indeed of the "complete personality." See E. HEIDBREDER, *supra* note 55, at 250, 254. Like the Soviet psychiatrists, he rejected the Freudian model and the significance of instinctual drives. *Id.* at 255. In an oft-quoted statement, he boasted:

Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I'll guarantee to take any one at random and train him to become any type of specialist I might select—doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations, and race of his ancestors.

J. WATSON, *BEHAVIORISM* 82 (1925).

Nor did Watson, like the Soviets, shy away from the political consequences of the radical environmental determinism of the Pavlovian paradigm. Freedom was an illusion, he maintained. This theme was more fully developed in a popular book by Watson's best-known follower. See B. SKINNER, *BEYOND FREEDOM AND DIGNITY* (1971). Human choices were the mechanistic products of conditioning. The grand political question was whether man would be content with the "freedom of the libertine"—the product of an uncontrolled environment—or would exploit the technology of conditioning to bring up children "in behavioristic freedom—a freedom which we cannot even picture in words, so little do we know of it." E. HEIDBREDER, *supra* note 55, at 257 (quoting Watson). Asked Watson rhetorically: "Will not these children in turn, with their better ways of living and thinking, replace us as a society, and in turn bring up their children in a still more scientific way, until the world finally becomes a place fit for human habitation?" *Id.* at 257-58. See also R. WOODWORTH & M. SHEEHAN, *supra* note 49,

undesirable behavior in Eastern Europe⁶⁴ and the Peoples' Republic of China,⁶⁵ where the Pavlovian paradigm made little headway, underlines the importance of Pavlovian theory in the emergence of a psychiatric approach to Soviet dissent. For Soviet psychiatrists, Pavlovian principles were hardly a consciously cynical cover for totalitarian repression. Rather, they had genuine scientific appeal—and their own inevitable, anti-liberal political implications.

at 112; Schefflin, *Freedom of the Mind as an International Human Rights Issue*, 3 HUM. RTS. L.J. 1, 22-23 (1982).

64. There have been sporadic reports of psychiatric internments of dissidents in Eastern Europe. With the exception of a 1974 report of a Catholic priest's pre-trial detention in a mental hospital following complaints of police persecution, *see* S. BLOCH & P. REDDAWAY, *supra* note 5, at 465, there were no reports of political psychiatric commitments in Poland until the recent crackdown against the Solidarity trade union. But in 1982, an appeal reached the West from four martial law internees who reported they had been transferred to a psychiatric ward specializing in alcoholism. "None of us," the four asserted, "has ever needed psychiatric care." IAPUP, INFORMATION BULL. NO. 5, Oct. 1982, at 11-12. In Yugoslavia, a few cases of involuntary commitment for political activity have been reported. IAPUP, INFORMATION BULL. NO. 4, June 1982, at 7-8 (recounting commitment of two dissenters). A number of internments of dissidents have been reported in Romania as well. *See* IAPUP, INFORMATION BULL. NO. 6, Mar. 1983, at 17-18. In Czechoslovakia, the official *Handbook of Criminal Law* contains an article by a Security Services physician describing an illness termed "reforming paranoia." "Symptoms" include failure to vote (for the Party's choice), possession of forbidden literature, and expression of inappropriate opinions. At least one dissident has been psychiatrically interned on this ground. IAPUP, INFORMATION BULL. NO. 8, Feb. 1984, at 4. The only reported case in Hungary is that of a lawyer critical of the regime since the 1956 uprising. Twice in 1981-82 he was arrested and interned in a mental hospital for three-week periods after declaring hunger strikes and other activities in support of Poland's Solidarity union and its Hungarian backers. Each time, he was force-fed and administered the antipsychotic drug haloperidol, although his psychiatric diagnosis is unclear from the available reports. IAPUP, INFORMATION BULL. NO. 3, Mar. 1982, at 7; IAPUP, INFORMATION BULL. NO. 6, Mar. 1983, at 18. For two earlier, sporadic reports of political abuse of psychiatry in Eastern Europe, *see* S. BLOCH & P. REDDAWAY, *supra* note 5, at 465.

65. There appear to be no reports of Soviet-style psychiatric internments in the PRC. This may reflect the very limited role of mental health professionals and institutions in China. They treat only overtly psychotic or otherwise severely disabled patients; for those less severely troubled, local cadres "prescribe" political education, job training, and employment. *See* Interviews with several Ministry of Health officials, in Peking (July, 1979) (copy on file with the author). But the unique program of *szu-hsiang kai-tsao* (thought reform), conducted by non-medical personnel in penal institutions, has been the primary tool against political dissent since the inception of the communist system in China. The key elements of the program are the use of alternating harsh and humane living conditions and intense emotional and intellectual pressure by peers, to convince a prisoner to acknowledge his ideological "errors" and "reeducate" him in the values and beliefs of the new communist man. *See generally* R. LIFTON, *THOUGHT REFORM AND THE PSYCHOLOGY OF TOTALISM* (1963) (psychoanalytic study of Chinese thought reform program building upon Erik Erikson's concept of identity).

III. The Legal Framework for Psychiatric Internment of Soviet Dissidents

A. *Khrushchevian Reform*

After Stalin's death in 1953, a new, collective leadership embarked on the most remarkable campaign of reform in Soviet history. At the core of the wide-ranging program of "de-Stalinization" was a determination to place Soviet society on a new foundation of "socialist legality." Scarred by memories of Stalinist brutality and the arbitrariness of the "cult of personality," Soviet legal reformers, with two related objectives in mind, set out to redesign the nation's criminal law.

First, they aspired to end the use of criminal process and sanctions as blunt weapons of class warfare. For Stalin, the primary purpose of the criminal law was to punish and to deter "enemies of the people."⁶⁶ The reformers embraced the rehabilitative ideal and called for "preventive and educational measures which remove those factors contributing to the appearance of survivals of the past in people's minds."⁶⁷ Linked to the rehabilitative ideal was the therapeutic ideal. As Khrushchev explained: "A crime is a deviation from the generally recognized standards of behavior, frequently caused by mental disorder."⁶⁸

Second, the reformers hoped to restrain the summary and arbitrary exercise of administrative and judicial power by drafting a wide range of safeguards for the criminally accused. They urged an end to Stalinist secret police tribunals and summary process for political cases.⁶⁹ They also proposed a right to counsel during pre-trial investigation, stricter rules of evidence, and even a presumption of innocence.⁷⁰ Moreover, they pressed for the elimination of the legal doctrine, dating back to

66. Juviler, *Some Trends in Soviet Criminal Justice*, in *SOVIET LAW AFTER STALIN*, PART III: *SOVIET INSTITUTIONS AND THE ADMINISTRATION OF LAW* 60 (D. Barry, F. Feldbrugge, G. Ginsburgs & P. Maggs eds. 1979) [hereinafter cited as *SOVIET LAW AFTER STALIN*]. Juviler also identifies recruitment of forced labor as a prime function of Soviet criminal justice. Deterring "ordinary" (nonpolitical) crime was a secondary concern. In the Stalinist camps, persons sentenced for "counterrevolutionary crimes" outnumbered ordinary criminals several times over. *Id.* at 59-60.

67. *Id.* at 61 (quoting a Politburo member). The reformers launched an ambitious program designed to transfer much of the responsibility for enforcing "the rules of socialist community life" from the criminal justice system to informal community groups, including "general assemblies" of neighbors and volunteer "comrades-courts." Juviler, *Criminal Law and Social Control*, in *CONTEMPORARY SOVIET LAW* 26-35 (D. Barry, W. Butler & G. Ginsburgs eds. 1974).

68. S. BLOCH & P. REDDAWAY, *supra* note 5, at 62.

69. Juviler, *supra* note 67, at 22.

70. *Id.* at 22-23.

tsarist times, that empowered judges to convict and to sentence any person believed guilty of a "socially dangerous" act, regardless of whether the act was specifically defined in the Criminal Code.⁷¹

The reform campaign climaxed in 1958 with the enactment of sets of "Fundamental Principles" of criminal law and procedure, to which the Union Republics were required to adhere in revamping their criminal codes.⁷² By 1961, all the Republics had dutifully adopted conforming codes of criminal law and procedure.⁷³ The new codes rejected the old idea of criminal liability for acts deemed "socially dangerous" yet not specified by statute,⁷⁴ and they barred the closed police tribunals and summary process of the Stalinist era.⁷⁵ Though they fell far short of Western, liberal standards of procedural due process and well-crafted substantive criminal law,⁷⁶ the codes created a formidable barrier to the imposition of criminal sanctions without formalized judicial proceedings.⁷⁷

By Soviet standards, then, Khrushchev's law reform campaign produced a remarkable liberalization. Ironically, this liberalization created a legal framework for the political use of psychiatry that eventually aroused widespread condemnation in the West. The collective leadership of the Khrushchev era remained no less committed than its predecessors to the Leninist conception of political expression. The only legitimate function of political expression was to teach and to inspire the masses to strive toward the Party's vision of socialism. Dissent—even intramural, Marxist dissent—had no place. The success of the post-Stalin law reform

71. Under this doctrine, known as "Analogy," a judge could convict simply by drawing a parallel, however far-fetched, between the defendant's act and some crime explicitly defined in the Code. This, of course, rendered Code definitions, however circumscribed, virtually useless as safeguards if the defendant's act fit a judge's notion of what was "socially dangerous." See J. HAZARD, I. SHAPIRO & P. MAGGS, *THE SOVIET LEGAL SYSTEM* 136-37 (1969).

72. Juviler, *supra* note 67, at 23.

73. *Id.*

74. Article 7 of the 1958 General Principles of Criminal Law states:

As a crime shall be considered, *if it is so specified by a criminal statute*, any socially dangerous act (of commission or omission) attacking the Soviet social or political order; socialist system of economy; socialist property; persons; political, labor, property and other rights of citizens; as well as any other socially dangerous act attacking the socialist legal order, *if so specified by a criminal statute*.

Cited in K. GRZYBOWSKI, *SOVIET LEGAL INSTITUTIONS: DOCTRINES AND SOCIAL FUNCTIONS* 204 (1962) (emphasis added).

75. Even so, the law reformers got less than they had wanted. Instead of the presumption of innocence standard that they had sought, for instance, a rule that was adopted placed the burden of proof upon the prosecution. Juviler, *supra* note 67, at 22.

76. See K. GRZYBOWSKI, *supra* note 74, at 182-215.

77. The General Principles of Criminal Law decreed that a person may be neither convicted nor criminally penalized except by a court. *Id.* at 196. But, as Grzybowski notes, the administration of justice by community administrative organizations (formally non-criminal) has, in practice, eroded this barrier. *Id.*

campaign, however, undermined the ability of the criminal process to effectively squelch dissent. Criminal and civil psychiatric internment offered Soviet authorities a bypass around the criminal process to achieve this result.

After Khrushchev's liberalizations, instead of secret police tribunals, summary procedures, and the old idea of criminal liability for any act that might retrospectively be declared "socially dangerous," the State had at its disposal only a small set of statutes dealing with specified anti-Soviet acts. These statutes were quite general and open to expansive judicial interpretation,⁷⁸ unrestrained by Western-style due process requirements of definitional precision.⁷⁹ Yet they required the State to attempt to identify discrete acts allegedly committed and at least arguably cognizable. Once the State did so, the provisions framed issues for debate—including questions of definition and intent—which simmered with both latent and explicit political content.⁸⁰

78. In the Russian Soviet Federated Socialist Republic (RSFSR), where the 1960 Criminal Code remains in effect with only minor revisions, the harsher of the two provisions most commonly invoked against dissenters bars: (1) "[a]gitation or propaganda carried on for the purpose of subverting or weakening the Soviet regime;" (2) "commit[ting] particularly dangerous crimes against the state;" (3) "dissemination for the said purposes of slanderous inventions defamatory to the Soviet political and social system;" and (4) "dissemination or production or harboring for the said purpose of literature of similar content." R.S.F.S.R. CRIM. CODE art. 70 (punishable by 2 to 5 years exile, a 6-month to 7-year prison term, or both), *reprinted in* Feldbrugge, *Law and Political Dissent in the Soviet Union*, in CONTEMPORARY SOVIET LAW, *supra* note 67, at 60. The less severe provision prohibits (1) "[s]ystematic dissemination in oral form of deliberately false inventions, discrediting the Soviet political and social system," and (2) "production or dissemination in written, printed, or other form of works of similar content." R.S.F.S.R. CRIM. CODE art. 190-1 (punishable by up to 3 years in prison, up to 1 year of "corrective labor," or a fine of up to 100 rubles), *reprinted in id.* at 63. According to one Western expert in Soviet law, the essential difference between these provisions is the requisite degree of intent: Article 70 requires a specific anti-Soviet purpose (so-called direct intent), while article 190-1 requires merely that the accused have acted with knowledge of the anti-Soviet consequences (indirect intent). *Id.* at 60-64. Defendants frequently plead a reduction of the charge from article 70 to article 190-1, and courts occasionally grant this reduction. *Id.* at 64.

79. See, e.g., *Coates v. City of Cincinnati*, 402 U.S. 611 (1971) (criminal ordinance banning any sidewalk conduct "annoying to persons passing by" held, *inter alia*, to violate due process standard of vagueness).

80. In addition to the provisions in articles 70 and 190-1, *see supra* note 78, other RSFSR criminal code provisions are occasionally used against dissidents. These include: article 64 ("Betrayal of the Homeland," which includes "joining the enemy," espionage, "revealing a state or military secret," "escaping to a foreign country," and "assisting a foreign state in inimical activity against the U.S.S.R."), *cited in* A. PODRABINEK, PUNITIVE MEDICINE 100 (1980); article 83 ("Illegal Exit Abroad," applied to attempted defectors not deemed to be politically motivated), *cited in id.*; article 72 ("Anti-Soviet Organizational Activity," applied to participation in political organizations not officially sanctioned), *cited in id.* at 106; article 75 ("Disclosure of a State Secret"), *cited in id.* at 114; article 209 ("Habitual Vagrancy"), *cited in id.* at 115. In addition, article 206 (hooliganism) and article 191 (resisting a police officer) are also invoked. See Feldbrugge, *supra* note 78, at 65.

Thus, ironically, the criminal justice process can serve as a forum for the political dialogue between dissenters and the authorities that the criminal law is designed to squelch.⁸¹ Denied access to legislative, mass media, and other public fora, dissenters willing to take the risk and bear the consequences can challenge the State in the criminal arena, protected by the "socialist legality" of the post-Stalin procedural code. In criminal proceedings against an adult defendant held legally responsible for his actions, the authorities are limited by the restrictions discussed above, the accused is guaranteed defense counsel once a pretrial investigation is complete,⁸² and—most significantly—the trial must be open.⁸³ This last, vague requirement has been inconsistently implemented. Trials for routine crimes without political overtones have generally been "open" to the public, while some trials of dissidents for political offenses have been "open" only to one or a few family members.⁸⁴ But even such limited "openness" in political trials permits the colloquy between a defiant dissenter and the State to leak out via underground verbal and *samizdat* channels to foreign media and eventually (via foreign, Russian language broadcasts) to many Soviet citizens.⁸⁵ The result is a tarnished political image abroad and an unwanted pluralism in the political messages heard at home. For the Soviet Union's post-Stalinist leaders, Khrushchevian "socialist legality" has had its political price.

Whether the designers of Soviet legal procedures for the internment of the mentally ill had in mind a way to silence dissenters without paying this price is a question for which we have no direct evidence.⁸⁶ But to a remarkable degree, the system they created provides effective legal tools for doing so. Soviet procedures for the determination of criminal responsibility and competency to stand trial make it simple to shunt dissenters along a low resistance path from the criminal forum to psychiatric institutions. Moreover, the Soviet system of civil commitment grants psychiatrists sweeping authority, unchecked by judicial process, to intern

81. See *id.* at 56-57 (law as vehicle for political argument).

82. See R.S.F.S.R. CRIM. PROC. CODE art. 47. There are few substantial differences between the Criminal Law and Procedure Codes of Russia and of the other Union Republics.

83. See KONSTITUTSII art. 157 (U.S.S.R.).

84. The trial of Vladimir Bukovsky is perhaps the most prominent example. See *infra* note 144.

85. A recent example is the 1981 trial of dissident psychiatrist Anatoly Koryagin, whose defiant courtroom words were smuggled out via *samizdat* to the Western press. See Transcript of Koryagin trial (1981) (unpublished, *samizdat* document, copy on file with the *Yale Journal of International Law*).

86. Those partial to "simple evil" explanations of Soviet psychiatric practices appear to assume such intent without articulating their reasons. See, e.g., Chodoff, *Ethical Conflicts in Psychiatry: The Soviet Union Vs. The U.S.*, 36 HOSP. & COMMUNITY PSYCH. 925, 926 (1985).

anyone they believe may in the future commit "socially dangerous" (including dissenting) acts.

B. *Criminal Commitment*

1. The Legal Test

The basic Soviet rule for determining criminal responsibility requires that a defendant who has committed a "socially dangerous" criminal act be found "not responsible,"⁸⁷ if when committing the act he could not "realize the significance of his actions or control them because of a chronic mental illness, temporary mental derangement, mental deficiency, or other condition of illness."⁸⁸ This formulation is notably similar to the American Law Institute's Model Penal Code rule, which has been widely adopted by the United States circuit courts of appeals.⁸⁹ According to the A.L.I. rule, "[a] person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law."⁹⁰ For non-responsibility, both the Soviet and A.L.I. rules require that mental illness has *caused* either a loss of ability to comprehend a criminal deed's "significance" ("criminality") or a loss of "control" ("capacity" to "conform" to law) over one's behavior.

This formulation, as Judge Bazelon has observed, is vulnerable to application in ways that abdicate to medical experts the moral questions at the core of the criminal responsibility issue.⁹¹ Bazelon points to two problems. First, the requirement of mental disease permits psychiatrists, armed with their own value-laden conceptions of what patterns of thought and behavior constitute mental illness, to impose their moral choices on the legal system by the act of diagnosis.⁹² Second, the undefined causation requirement invites psychiatrists to testify in a conclusory manner as to whether a defendant's impairment resulted in his criminal behavior. In so doing, psychiatrists veil, behind their jargon, particular conceptions of legally cognizable causation. Such conceptions reflect political premises— notions about whether particular theories of "but for" causation ought to justify exculpation. For every human act has its

87. The Russian term *nevmeniaemyi* is also variously translated as "non-imputable" and "insane." Feldbrugge, *supra* note 78, at 67.

88. R.S.F.S.R. CRIM. CODE art. 11.

89. *United States v. Brawner*, 471 F.2d 969, 973 (D.C. Cir. 1972).

90. MODEL PENAL CODE § 4.01(1) (Tent. Draft No. 4, 1955).

91. *Brawner*, 471 F.2d at 1017-30 (Bazelon, C.J., concurring in part and dissenting in part) (criticizing A.L.I. rule).

92. For a tartly perceptive commentary on the attraction and power of diagnosis as a political and moral tool in American political life as well as in American and Soviet courtrooms, see Reich, *The Force of Diagnosis*, HARPER'S, May 1980, at 20.

complex web of “but for” causes, and the legal issue of criminal responsibility is at heart a question of which causes should count.⁹³

The law of criminal responsibility in the Soviet Union thus allows wide deference to whatever value-laden notions of normality and deviance are embodied in prevailing psychiatric doctrine. As the A.L.I. rule demonstrates, though, the Soviets are hardly unique in this regard. Were political dissent a crime under American law and a sign of illness according to American psychiatric theory, the inevitable implication of the A.L.I. rule would be the criminal insanity of dissenters. The Soviet test of criminal responsibility, in short, invites the conceptualization of dissent as disease, but this is not due to any basic difference from Western rules for determining responsibility.

Curiously, the Soviet test of competency to stand trial is almost identical to the criminal responsibility rule—a defendant may not be tried (or sentenced) if “mental illness . . . deprives him of the possibility of realizing the significance of his actions or of controlling them.”⁹⁴ Thus, on competency as well as on criminal responsibility, Soviet substantive law defers to the aura of psychiatric expertise, again easing the way for disposal of dissenters as diseased.

93. Judge Bazelon draws an analogy between the concept of illness in the law of criminal responsibility and the tort concepts of duty and proximate cause. His analogy applies equally to the causation requirement of the A.L.I. and Soviet rules. All are artificial concepts—instruments for effecting policy judgments about where legal responsibility should lie. *See United States v. Eichberg*, 439 F.2d 620, 625 (D.C. Cir. 1971) (Bazelon, C.J., concurring). In tort law, contrasting moral visions of fairness, economic principles of loss-spreading and efficient cost-avoidance, and other policy considerations vie for implementation in the form of rules about duty and proximate cause. Similarly, in criminal law, conflicting moral ideals of human responsibility vie with retributive, rehabilitative, and deterrent goals for effectuation as principles of legally cognizable culpability.

94. R.S.F.S.R. CRIM. CODE art. 11. In contrast, American tests of competency focus on the accused's ability to understand the charge and participate in his defense. Such a focus is more directly germane to the task of criminal defense and less subject to conclusory psychiatric testimony that may reflect doctors' prejudices—irrelevant to the narrow question of competency—about whether the accused should be hospitalized. Surely, if the issue is the accused's capacity to participate in his own defense, it is irrelevant whether the accused is mentally ill or whether mental illness is the cause of the accused's impairments. The only component of the Soviet rule conceivably relevant is the issue of whether the defendant can “realize the significance of his actions.” An explanation for this apparent confusion may lie in the precept that the central function of Soviet criminal law is the teaching of principles of socialist morality. *See generally* Berman, *The Educational Role of Soviet Criminal Law and Civil Procedure*, in *CONTEMPORARY SOVIET LAW*, *supra* note 67, at 1-16. If pre-trial factual investigation is thought to have determined whether the accused has physically committed the proscribed act, then the question of competence to stand trial becomes a question of the value of the trial as an educational proceeding. If, because of mental illness, an individual can neither control his actions nor realize their significance, the trial has no educative potential, and socialist morality is better inculcated by mental health professionals.

2. The Criminal Process and Psychiatric Examination

The Soviet system of criminal procedure contributes further to the tendency to treat dissent as disease. After a defendant has been arrested and charged, investigators from the Procuracy⁹⁵ begin a pre-trial inquiry. Either they or the court may order a psychiatric examination at any time before or during trial.⁹⁶ Psychiatrists are selected and appointed by the investigator or the court,⁹⁷ to whom they must report their conclusions. Procedures are identical for questions of criminal responsibility and competency to stand trial. Examinations are generally conducted by commissions of three psychiatrists (fewer in remote regions) under detailed guidelines issued by Moscow's Serbsky Institute of Forensic Psychiatry.⁹⁸ The accused, his family or guardian, and his defense counsel may ask the court for a psychiatric consultation. The court, however, may refuse⁹⁹ and usually does. In accord with Soviet rejection of the adversarial system,¹⁰⁰ psychiatric examiners appointed by investigators and courts are officially viewed as impartial and objective;¹⁰¹ thus defense consultation with experts is deemed unnecessary. Soviet authorities assert that because all examiners, including the Serbsky Institute's psychiatric *doyens*, are employed by agencies under the aegis of the U.S.S.R. and Union Republic Ministries of Health, they are independent of investigators' pressures.¹⁰² But Soviet law permits investigators to be present during psychiatric examinations,¹⁰³ and several dissidents have reported

95. The Procuracy (*Prokuratura*) is a State organ with a broad constitutional mandate to monitor and enforce governmental officials' and individuals' compliance with law. In criminal proceedings, the agency's attorneys serve as investigators, prosecutors, and supervisors of the legality of judicial proceedings and decisions. 2 ENCYCLOPEDIA OF SOVIET LAW 545-48 (F. Feldbrugge ed. 1973). This combination of roles reflects Soviet rejection of principles of separation of powers and adversarial jurisprudence as bourgeois notions, unnecessary in a society without class interests.

96. R.S.F.S.R. CRIM. PROC. CODE art. 79. Investigators need not obtain court approval to issue such an order. Moreover, if psychiatric examiners evaluate a defendant in prison or as an outpatient and then conclude that there is a "necessity for constant observation" to complete the evaluation, an investigator has the authority to commit the accused to a hospital without judicial approval. R.S.F.S.R. CRIM. PROC. CODE art. 188.

97. Forensic Psychiatric Examination in the USSR, Instruction approved Oct. 27, 1970, reprinted in A. PODRABINEK, *supra* note 80, at 203-08 [hereinafter cited as Instruction on Forensic Psychiatric Examination]. Psychiatrists so appointed are legally required to serve, on pain of criminal sanction. R.S.F.S.R. CRIM. CODE art. 182.

98. Instruction on Forensic Psychiatric Examination, *supra* note 97.

99. S. BLOCH & P. REDDAWAY, *supra* note 5, at 99.

100. *See supra* note 95.

101. A. PODRABINEK, *supra* note 80, at 123.

102. *Id.* *See also* Instruction on Forensic Psychiatric Examination, *supra* note 97, at 203-04.

103. R.S.F.S.R. CRIM. PROC. CODE art. 190. No defense representative has this right.

that psychiatrists at the Serbsky Institute have military ranks in the Ministry of Internal Affairs (MVD), a security organ that takes orders from the Procuracy and the KGB.¹⁰⁴

Soviet criminal procedure renders a defendant legally impotent to challenge psychiatric disposition of his case. When a pre-trial investigator orders a psychiatric evaluation, she need not inform the accused. Nor must the forensic commission reveal its conclusions and recommendations to the defendant if the commission concludes that "his mental state makes this [disclosure] impossible."¹⁰⁵ Moreover, the accused loses the right to be told the results of the criminal investigation, shown materials compiled by the investigators, and informed if new charges are brought against him.¹⁰⁶ While undergoing in-patient examination, he is generally denied visits from family members and access to a lawyer.¹⁰⁷ Nor is the accused's lawyer "permitted to participate in a case [until after] the fact of the mental illness of the [criminal] is established."¹⁰⁸

After the psychiatric examiners' conclusions have been submitted, the court holds a summary hearing, in lieu of a full-scale trial, to decide several issues: (1) whether the defendant has committed a socially dangerous crime; (2) whether to accept the examiners' findings on the question of criminal responsibility (or competency to stand trial); and (3) what measures to apply.¹⁰⁹ The accused has no right to attend this hearing.¹¹⁰ Access is left to the court's discretion, but in political cases¹¹¹ the defendant is rarely allowed to be present.¹¹² In such cases, moreover, courts almost always approve the psychiatric commission's findings on responsibility¹¹³ (or competency) and recommendations as to the disposition of the accused.¹¹⁴ Theoretically, Soviet law gives psychiatric examiners and

104. See, e.g., V. NEKIPELOV, *INSTITUTE OF FOOLS: NOTES FROM THE SERBSKY* 26-27 (1980).

105. R.S.F.S.R. CRIM. PROC. CODE art. 184.

106. AMNESTY INTERNATIONAL, *supra* note 1, at 6.

107. *Id.*

108. R.S.F.S.R. CRIM. PROC. CODE art. 405.

109. AMNESTY INTERNATIONAL, *supra* note 1, at 6.

110. *Id.*

111. See, e.g., R.S.F.S.R. CRIM. CODE arts. 70 and 190-1 (cases arising under these articles). See also *supra* note 78.

112. AMNESTY INTERNATIONAL, *supra* note 1, at 6.

113. Feldbrugge, *supra* note 78, at 67.

114. AMNESTY INTERNATIONAL, *supra* note 1, at 6. In rare instances an investigator or a court will question a commission's conclusions and request a second examination. S. BLOCH & P. REDDAWAY, *supra* note 5, at 100. The Serbsky Institute is responsible for organizing all such reexaminations. Instruction on Forensic Psychiatric Examination, *supra* note 97, at 203-07. In some especially sensitive political cases, Serbsky staff members themselves conduct the examination; when the results of two examinations conflict, a court almost always adopts the Serbsky's opinion. S. BLOCH & P. REDDAWAY, *supra* note 5, at 100. See, e.g., IAPUP, INFORMATION BULL. No. 3, Mar. 1982, at 11 (case of Vasily Spinenko, a philosophy student who proposed a philosophic alternative to Marxism and capitalism, was arrested and twice

courts three options for disposition of defendants found non-responsible or incompetent: they may be (1) discharged into the custody of a guardian; (2) interned in a so-called Ordinary Psychiatric Hospital (OPH) if found "dangerous"; or (3) committed to a Special Psychiatric Hospital (SPH) if found "especially dangerous."¹¹⁵ No political defendant found non-responsible or incompetent is known to have been discharged, and confinement to SPH's (operated by the MVD) has been common.¹¹⁶

3. The Role of Value Preferences

In numerous ways, this complex process of psychiatric evaluation and disposal invites investigators, courts, and doctors to effect their moral preferences about responsibility, normality, and deviance by enveloping them in a "scientific" aura of medical authority. This is hardly a uniquely Soviet phenomenon; critics of psychiatry's role in the American criminal process repeatedly make this point.¹¹⁷ The parallels between the problem in the Soviet Union and Western nations are curiously overlooked by the "simple evil" theorists. But peculiar features of the Soviet process, linked largely to the Marxist-Leninist rejection of the adversarial system and of a truly independent judiciary, greatly magnify the phenomenon in the U.S.S.R. In a context of deep-seated acceptance of authority and rejection of political pluralism,¹¹⁸ it is hardly surprising that this situation, coupled with a psychiatric conceptualization of resistance to authority as a symptom,¹¹⁹ could pave a legal path towards psychiatric internment of dissenters.

A defendant first experiences this troubling feature of the Soviet process when an investigator orders a psychiatric exam. Soviet law articulates no clear standard for an investigator to apply in determining whether to order an exam. The investigator is thus left to rely upon his own personal notions of normality and deviance, including beliefs about the peculiarity of any challenge to respected authority.¹²⁰ The American procedure of judicially-ordered commitment for examination is similarly

found responsible by psychiatric commissions, then examined by the Serbsky, which diagnosed "sluggish schizophrenia" and found him non-responsible).

115. See R.S.F.S.R. CRIM. CODE arts. 58-60.

116. AMNESTY INTERNATIONAL, *supra* note 1, at 6. The SPH's are high-security facilities for the criminally insane. In contrast, the OPH's (run by the Ministry of Health) are populated largely by civilly committed and voluntary patients.

117. See, e.g., *Washington v. United States*, 390 F.2d 444 (D.C. Cir. 1967) (Bazelon, C.J.) (sharply criticizing psychiatrists' courtroom use of diagnostic labels that hide value choices).

118. See *infra* notes 305-09 and accompanying text.

119. See *infra* text accompanying notes 247-95.

120. See *infra* notes 305-09 and accompanying text.

vulnerable to some degree to personal hunches about who is "sick."¹²¹ But there are critical *procedural* differences: while a Soviet investigator has unreviewable authority to order a commitment for examination, an American jurist does so with the knowledge that a person committed involuntarily can demand judicial review of the legality of her confinement and that adversarial dialogue might spotlight for scrutiny a decisionmaker's personal bias.¹²² There is no reason to think that Soviet commitments for examination are any more prone to crude biases about a behavior's peculiarity than are American commitments. But without adversarial proceedings and judicial review, these biases are much less open to careful evaluation and thus more snugly cloaked in the scientific mantle of diagnosis.

Once a Soviet defendant is in the hands of his psychiatric evaluators, a different set of circumstances operates to envelop political choices about his disposition in the aura of medical authority. First, forensic examiners are officially required not only to investigate and report on the accused's mental processes, but also to reach conclusions on the issue of legal responsibility.¹²³ Moreover, since psychiatric opinions are subjected to only minimal cross-examination, there is no opportunity for the judicial process to separate doctors' moral and legal notions from their technical reasoning about psychopathology. Instead, these notions are uncritically accepted by the courts, which routinely adopt experts' conclusions after only cursory scrutiny.¹²⁴ The liberal precept of separation between issues

121. The American procedure's vulnerability to personal hunches is illustrated by one New York state case in which a landlord with numerous prior convictions for unlawful conditions in his building attempted to plead guilty to a similar offense. *People v. Warden of City Prison*, 37 Misc. 2d 660, 235 N.Y.S.2d 531 (Sup. Ct. 1962). An irritated magistrate endured the defense attorney's plea for mercy, but then snapped:

I don't think I have ever had a defendant before me who was as cruel as you are, absolutely callous to the feelings of other people, little children, sick children. . . . You pay no attention to the authorities, no attention to the courts, no attention to these inspectors. . . . I don't think that you could possibly be normal—so therefore you are committed to Bellevue for examination.

Id. at 662, 235 N.Y.S.2d at 536. This commitment not only reflected the magistrate's crude equating of moral ugliness with mental illness; it expressed his anger at a person apparently unresponsive to the moral force of the criminal process.

122. Thus, in *Warden of City Prison*, the defendant's subsequent writ of habeas corpus forced a fresh adversarial dialogue over the commitment's propriety. On appeal, it was held that the magistrate's treatment of the landlord's callousness as a disease *per se* was contrary to the law's precept of individual responsibility. *Id.* at 675, 235 N.Y.S.2d at 549.

123. Instruction on Forensic Psychiatric Examination, *supra* note 97, at 203; *see also* Kalashnik, *The Legal Position and Organizational Forms of Forensic Psychiatric Expert Examination*, in *FORENSIC PSYCHIATRY* 24 (G. Morozov & I. Kalashnik eds. 1970) (English translation of official Soviet forensic psychiatry textbook).

124. *See supra* text accompanying notes 113-14.

of fact and value is foreign to Soviet jurisprudence,¹²⁵ which in technically complex matters defers to forensic experts on questions of both fact and law.

This Western ideal of separation, it is true, is conceptually problematic and arguably unrealizable.¹²⁶ When the United States court of appeals declared that an accused should be found not criminally responsible if his unlawful act "was the product of mental disease or mental defect,"¹²⁷ it reached out daringly toward the separatist ideal. The court hoped that psychiatrists would testify only as to "the development, adaptation, and functioning of . . . [emotional] processes and [behavioral] controls."¹²⁸ The jury was then to decide, as a moral question, whether any purported impairments in these processes and controls constituted "mental disease or defect for the . . . purpose [of] determining criminal responsibility."¹²⁹ In other words, the core value issue—whether psychiatric explanation justified legal exculpation—was to be left to the jurors. But this judicial experiment ended in disillusionment. Psychiatrists' diagnostic labels, the court finally concluded, concealed doctors' judgments about defendants' blameworthiness.¹³⁰ "We assumed," Judge Bazelon wrote for the court, "that the expert could separate the medical judgments which he was supposed to make from the legal and moral judgments which he was not supposed to make. It has become abundantly apparent that this theory has not worked out."¹³¹

The principle of separation, however, must retain some force if an expert's technical prowess is not always to imply a right to unchecked moral authority. Without "practical distinctions between the technical and the political," one critic of separation has acknowledged, there is nothing to prevent experts "from using their discretion gradually to draw political decisions under the cloak of expertise"¹³² Even after Judge Bazelon's confession of disillusion, the D.C. Circuit continued to

125. For the Marxist-Leninist, there are no "value questions" in the liberal, Weberian sense, because the "Marxist-Leninist science of society" and its laws of social development provide correct answers to all questions of social, political, and legal choice. See S. BLOCH & P. REDDAWAY, *supra* note 5, at 44 (quoting Stalin on scientists' obligation to learn and apply this "science of society").

126. See, e.g., Yellin, *Science, Technology, and Administrative Government: Institutional Designs for Environmental Decisionmaking*, 92 YALE L.J. 1300 (1983) (arguing that science policy issues involving tenuous evidence and uncertain predictions cannot be neatly separated into technical and legal component questions).

127. *Durham v. United States*, 214 F.2d 826, 875 (D.C. Cir. 1954).

128. *McDonald v. United States*, 312 F.2d 847, 851 (D.C. Cir. 1962) (en banc).

129. *Id.*

130. *Washington v. United States*, 390 F.2d 444, 453 (D.C. Cir. 1967).

131. *Id.* at 452.

132. Yellin, *supra* note 126, at 1328 (discussing scientific expertise in federal administrative agencies).

grope for such "practical distinctions," resisting a total surrender to psychiatrists' moral judgments.¹³³ Persistent judicial discussion of the need for distinctions may sensitize American psychiatrists to the limits of their forensic role. Moreover, effective cross-examination can probe beneath conclusory diagnostic labels to discern hidden moral premises. By contrast, the Soviets' total rejection of the principle of separation constitutes *carte blanche* for Soviet legal institutions to cover questions of criminal responsibility "under the cloak of expertise."

4. The Role of the Forensic Psychiatrist

The individual Soviet psychiatrist, however, may have little latitude to exercise personal bias independently when performing forensic duties. In preparing a forensic evaluation, the clinician faces at least three potential sources of political guidance—the Serbsky Institute's "methodological and scientific management" of all examinations,¹³⁴ *ex parte* "inquiries" by the Party,¹³⁵ and the Procuracy investigator.¹³⁶ The "simple evil" theorists have interpreted this political guidance as convincing proof that Soviet forensic examiners are cynically obedient participants in a conscious conspiracy to abuse their medical patina for repressive ends.¹³⁷ That conclusion, however, is hardly obvious. Little information has reached the West on the precise nature of the guidance or pressure that comes from these bureaucratic avenues.¹³⁸

133. In *Washington*, the court opted to preserve the "product of mental disease or mental defect" test but decreed that "psychiatrists should not speak directly in terms of 'product' or even 'result' or 'cause'." 390 F.2d at 455-56. Rather, they "should explain how defendant's disease or defect relates to his alleged offense, that is, how the development, adaptation and functioning of defendant's behavioral processes may have influenced his conduct." *Id.* at 456. The court issued a detailed "Instruction" for psychiatrists, urging avoidance of moral judgments and warning: "[Y]ou may not state conclusions or opinions as an expert unless you also tell the jury what investigations, observations, reasoning, and medical theory led to your opinion." *Id.* at 457. Eventually, though, the court in *United States v. Brawner*, 471 F.2d 969 (D.C. Cir. 1972) gave up on such painstaking attempts to fine-tune the *Durham* "product" test, and instead replaced it with the A.L.I. rule. See *supra* note 90 and accompanying text. The *Durham* "product" requirement, the court reasoned, invited expert testimony that encroached on the jury's function. *Durham*, 471 F.2d at 983. The A.L.I. test's reduced emphasis on causation, the majority believed, would free jurors from "undue dominance" by experts. *Id.* at 981. But see *supra* text accompanying notes 91-93 (argument that A.L.I. rule does permit expert usurpation of value choices).

134. Instruction on Forensic Psychiatric Examination, *supra* note 97.

135. There is much evidence of systematic Party intervention in individual criminal cases. *Ex parte* contacts are officially justified on the ground that there is a distinction between legitimate "inquiry" and improper "pressure;" it is necessary for Party organs "to demand of State organs the grounds for the correctness of their actions" Juviler, *supra* note 66, at 68 (quoting an official Party publication).

136. The investigator has the right to be present during the examination. See *supra* note 103 and accompanying text.

137. S. BLOCH & P. REDDAWAY, *supra* note 5, at 263-72.

138. Virtually all Western information about Soviet psychiatric practices has come from official statements, carefully molded in accordance with Leninist concepts of publicity, and

What is known, though, is that the theories of the "Moscow School" of psychiatry, centered at the Serbsky and several other nationally prestigious institutions, are taught uncritically to medical students and psychiatrists-in-training throughout the Soviet Union. Like nascent professionals anywhere, young Soviet physicians absorb and integrate the values, beliefs, and theoretical constructs of their teachers and role models.¹³⁹ They do so, moreover, in a climate of common awareness that the moral and political qualities esteemed by the Party are vital to career advancement.¹⁴⁰ An estimated twenty-five percent of the Soviet medical curriculum is devoted to Marxist-Leninist theory.¹⁴¹ In acute contrast to the Hippocratic Oath's individualistic focus, the oath sworn to by young Soviet physicians stresses each one's obligation to be "*guided by the principles of communist morality*, ever to bear in mind . . . my responsibility to the people and the Soviet state."¹⁴²

Much evidence suggests that cynicism about communist ideals is now endemic in the Soviet Union, even among Party members and elite professionals.¹⁴³ Yet this is hardly a sufficient basis to presume that Soviet psychiatrists do not at all genuinely believe in, and respond to, the moral and patriarchal legitimacy of the Party and the State. More plausibly, the average forensic examiner is guided by a sort of "triplethink"¹⁴⁴—a complex mindset of duty, conformity, and hypocrisy—reflecting inculcated values, pragmatic caution, and swallowed doubt. If so, then the mandatory guidance of the Serbsky, the Party's ex parte "inquiries," and the investigator's right to attend examinations may be primary reminders of sensed obligation, not means of commanding medically garbed marionettes.¹⁴⁵

from dissident sources who can usually only speculate or draw indirect inferences about relationships between psychiatrists and Soviet officialdom.

139. Cf. Reich, *Diagnosing Soviet Dissidents*, HARPER'S, Aug. 1978, at 35 (psychiatrists' training strengthens biases); C. BOSK, FORGIVE AND REMEMBER (1979) (surgeons-in-training in American hospitals win professional acceptance and career opportunities not, primarily, through displays of technical virtuosity or intellectual excellence, but by coolly conforming to and integrating the personal and professional styles of their elders).

140. S. BLOCH & P. REDDAWAY, *supra* note 5, at 44.

141. *Id.* (quoting an emigré Soviet psychiatrist).

142. *Id.* at 43 (quoting translation of Soviet oath) (emphasis in original).

143. See generally K. SIMIS, USSR: THE CORRUPT SOCIETY (1982) (emigré Soviet lawyer's report on widespread cynicism and official corruption).

144. The term is Vladimir Bukovsky's. See Thorne, *Mother Courage: How Vladimir Bukovsky Was Saved*, N.Y. Times, Feb. 27, 1977, § 6 (Magazine), at 52.

145. Dissenters Vladimir Bukovsky and Dr. Semyon Gluzman, a psychiatrist, suggest sardonically that Soviet psychiatrists fall into six categories: (1) the enthusiastic "novice," who sincerely believes in the values and concepts of his elders and applies them uncritically (but is not generally named to forensic commissions); (2) the "academic," who has retained his "youthful" commitment to these values and concepts but regards forensic work as beneath his role as a doctor; (3) the "writer of a dissertation," who unconsciously tries to extend the

5. Effects of a Finding of Criminal Non-Responsibility

Whatever the motivations of forensic examiners, their reports are laden with conclusory diagnostic phrases¹⁴⁶ that effectively obscure political choices about the disposition of political offenders. When a dissenter is found non-responsible, the result is not only the discrediting of his challenge to authority, but an end run around the requisites of post-Stalin "socialist legality." With only a summary court hearing, instead of the more complete trial guaranteed by Soviet law, a verdict of non-responsibility can be imposed upon a defendant.¹⁴⁷ Once interned, a person cannot challenge his continued detention. Rather, the law deems the individual to be mentally incompetent and thus without standing to make an appeal to the courts.¹⁴⁸ Interested persons, including relatives, may petition a court for the release of a criminally committed patient,¹⁴⁹ but such requests are rarely honored. In practice, patients are generally released only after reexamination by an official psychiatric commission, a procedure that the law mandates at least once every six months.¹⁵⁰ If a commission finds for continued detention, release is out of the question. But if the examiners recommend release or transfer from an SPH to an OPH, their findings are reviewed by a court, which must grant approval before a patient can be discharged or moved.¹⁵¹ Little is known in the

boundaries of the disease that is his specialty and eyes criminal defendants as clinical "material;" (4) the "Voltarian," who, "disillusioned with psychiatry, would prefer to talk about art and literature, but being a coward and a cynic, will 'convincingly' find the patient mentally sound 'so nobody can pin a thing on him';" (5) the "Philistine"—the average, well-adapted clinician—a "contemporary *rentier*" who sincerely regards non-conformity as abnormal, "yields easily to pressure from above, and always justifies himself (in his own eyes) by citing authorities and psychiatric 'schools';" and (6) the "professional hangman"—the only one of the six who "deliberately" looks to find political defendants non-responsible. Bukovsky & Gluzman, *A Manual on Psychiatry for Dissenters* (*samizdat* monograph smuggled out of a labor camp), reprinted in S. BLOCH & P. REDDAWAY, *supra* note 5, at 419, 429-30.

146. See, e.g., S. BLOCH & P. REDDAWAY, *supra* note 5, at 115, 139-40 (Serbsky Institute Commissions that examined dissident General Pyotr Grigorenko and poet Natalya Gorbanevskaya found mental illness and criminal non-responsibility, necessitating compulsory hospitalization, but failed to state reasons).

147. In the U.S., by contrast, in every state a defendant is presumed to be sane at the outset of the trial and must introduce sufficient evidence to put sanity at issue. Hagan, *The Insanity Defense: A Review of Recent Statutory Changes*, 3 J. LEGAL MED. 617, 623 (1983).

148. See S. BLOCH & P. REDDAWAY, *supra* note 5, at 101.

149. R.S.F.S.R. CRIM. PROC. CODE art. 412.

150. S. BLOCH & P. REDDAWAY, *supra* note 5, at 101. All reports are submitted to the court.

151. *Id.* Courts usually, but not always, approve reexaminers' release or transfer recommendations. In the case of Spinenko, see *supra* note 114, psychiatrists recommended in 1981 that he be released, but a town court ruled otherwise. Spinenko's relatives asked the Donetsk regional procurator to intervene, and in a highly unusual move, the procurator appealed the decision. The higher court ruled against the procurator, though, and Spinenko remained in the hospital. IAPUP, INFORMATION BULL. No. 3, Mar. 1982, at 11. Also in 1981, a touring psychiatric commission from the Serbsky Institute recommended that Anatoly Lupynos, an Amnesty International prisoner of conscience, be transferred from an SPH to an OPH. The

West about what prompts reexaminers and courts to grant or to deny release. But for political dissenters and would-be emigrés, recantation appears to be important, albeit not essential.

According to knowledgeable observers, Soviet psychiatric internments usually do not exceed maximum prison terms.¹⁵² But there are frequent exceptions to this observed pattern¹⁵³ that has no legal status as an official rule. Thus, for the internee, the bottom line is indefinite confinement. Moreover, Soviet internees are commonly released with severe legal encumbrances of indefinite duration. These include an obligation to attend and to obey orders from a psychiatric clinic and to have a legal disability status and a "social dangerousness" rating which, for dissidents, may result in prophylactic internments during high-profile public events.¹⁵⁴

The dilemma of indeterminate commitment for defendants found either incompetent to stand trial or not criminally responsible is not unique to the Soviet system. In the United States, too, defendants in some jurisdictions may be found incompetent or not responsible, then committed to mental institutions for periods far longer than the maximum sentence for a guilty verdict.¹⁵⁵ But statutes and case law in numerous U.S. jurisdictions limit criminal commitments for incompetency and for non-responsibility to the length of the maximum sentence for the offense charged or to some fraction thereof.¹⁵⁶ Furthermore, upon release, American internees generally may not be encumbered with anything like the outpatient legal restrictions of their Soviet counterparts.¹⁵⁷

transfer did not take place, leading Western observers to infer that a court ruled against it. *See id.* at 9.

152. *See* IAPUP, INFORMATION BULL. NO. 5, OCT. 1982, at 14-15.

153. *See, e.g.,* the case of Vladimir Rozhdestvov, who was charged in 1977 with violating R.S.F.S.R. CRIM. CODE art. 190-1 (denigrating the Soviet State carries maximum term of three years, *see supra* note 78), was found non-responsible and committed to an SPH, where he remained six years later still refusing to recant. S. BLOCH & P. REDDAWAY, *supra* note 2, at 98.

154. *See* S. BLOCH & P. REDDAWAY, *supra* note 5, at 101-02. Such events have included major holidays, visits by foreign leaders, and the 1980 Olympic Games.

155. The classic rationale is one of therapeutic compassion laced with insensitivity to the possibility that human dignity may lie, for the internee, in resisting the therapists' efforts to remold him in accordance with their ideals. *See, e.g.,* *Jones v. United States*, 463 U.S. 354 (1983) (length of hospitalization should depend solely on need for treatment; due process clause does not require that criminal commitment of persons acquitted by reason of insanity be limited to length of maximum sentence).

156. In Connecticut, for example, a defendant found incompetent to stand trial may be confined for treatment for no longer than 18 months or the maximum sentence he could receive, whichever is shorter. CONN. GEN. STAT. § 54-56d(i) (1985). Connecticut defendants acquitted by reason of insanity may be criminally committed for no longer than 25 years or the maximum sentence for the offense charged, whichever is shorter. CONN. GEN. STAT. § 53a-47(b) (1985).

157. In a few states, however, patients acquitted by reason of insanity may be legally required to take medication and attend outpatient psychotherapy as a condition of discharge.

Finally, all American internees have access to the courts and are at least theoretically protected by the right of habeas corpus.

In short, the Soviet system of criminal commitment has some characteristics strikingly similar to its counterparts in various American jurisdictions. But coupled with (1) a substantive criminal law that encompasses dissent, and (2) a medical conception of opposition to authority as a sign of illness,¹⁵⁸ the Soviet system leads inevitably to psychiatric internment of political dissidents. This tendency is augmented by features of Soviet criminal procedure that *are* different from their American counterparts—features that reflect the rejection of the adversarial process and the separation of questions of fact from issues of value, as well as a diminished regard for the dignity of individuals' consciously voluntary choices.

C. Civil Commitment

The post-Stalin reform campaign of the 1950's, which brought such dramatic change to Soviet criminal law, failed to achieve one of the reformers' most cherished goals—the comprehensive codification of Soviet administrative law and procedure.¹⁵⁹ The significance of this failure is vast. In a country where virtually all business, social service, scientific, and cultural affairs are conducted within state institutions, state administrative action is the transcendently important form of social regulation.¹⁶⁰ The protection of citizens' rights and interests depends largely on the procedural principles that govern administrative promulgation of general rules and handling of individual cases. Yet despite a Khrushchev-era campaign for the development and passage of a comprehensive, nationwide administrative procedure act, no all-Union or RSFSR procedural statutes exist to govern the activities of the myriad of state organs.¹⁶¹

158. See *infra* text accompanying notes 247-95.

159. See Barry, *The Development of Soviet Administrative Procedure*, in *SOVIET LAW AFTER STALIN*, *supra* note 66, at 1, 2.

160. Under the Soviet Constitution, only the Supreme Soviet and its Presidium (the "organs of State power") have the authority to enact statutes. The Council of Ministers, individual ministries, and state committees (the "organs of state administration") are empowered to issue general rules, or "normative acts," "on the basis of and in fulfillment of" statutes. In practice, "normative acts" are much more numerous than statutes and probably much more significant; indeed a prominent Soviet legal scholar has complained that substatutory enactments are "eclipsing" statutory law because of statutes' vagueness and the wide range of issues consequently covered by administrative rules. See *id.* at 4-6. This complaint has a familiar ring to American lawyers. In the Soviet Union, however, there are no provisions for judicial review, either of administrative rulemaking or administrative application of rules to individual cases.

161. In 1958, the U.S.S.R.'s leading scholar of administrative procedure published an article urging a separate codification of administrative procedure. But despite vibrant scholarly

The Soviet approach to civil commitment of the mentally ill should be considered in this disturbing light. In the U.S.S.R., civil commitment is an administrative action, vulnerable to all the arbitrariness possible without a law of administrative procedure. A 1971 directive issued by the Ministry of Public Health (in coordination with the Procurator and the Ministry of Internal Affairs) sets forth criteria and administrative requirements for civil commitment.¹⁶² Like most other administratively enacted rules, this document is not readily accessible to the Soviet public.¹⁶³ It was issued in numbered copies "for official use only" and was not leaked to the West until the late 1970's.¹⁶⁴ Moreover, like other Soviet administrative directives, it is not subject to judicial review for compliance with either constitutional or statutory requirements.¹⁶⁵ Nor does Soviet law require court approval or provide for any kind of appellate judicial review for individual commitment decisions made pursuant to the directive.¹⁶⁶

The status of civil commitment as an administrative function, insulated from the requisites of the judicial process, is an anomaly under Soviet law. Legal competence to inherit, bequeath, donate, or sell property is, under codified statutes of civil law and procedure, a question for the courts.¹⁶⁷ A prominent Soviet legal scholar, N. S. Malein, argues that

discussion of numerous codification proposals and general agreement among Soviet lawyers on the importance of procedure, no legislative action has been taken. *Id.* at 2.

162. Urgent Hospitalization of the Socially Dangerous Mentally Ill: Instruction of the Ministry of Public Health of the USSR, Aug. 26, 1971, reprinted in A. PODRABINEK, *supra* note 80, at 195 [hereinafter cited as Instruction on Hospitalization].

163. Only statutes (issued by the Supreme Soviet and its Presidium) and rules promulgated by the Council of Ministers must be published. Barry, *supra* note 159, at 7.

164. By 1977, parts of the 1971 directive had reached the West via the *samizdat* journal *Chronicle of Current Events*. S. BLOCH & P. REDDAWAY, *supra* note 5, at 155-56. Only later did the dissident Working Commission to Investigate the Use of Psychiatry for Political Purposes apparently obtain a complete copy. The directive appears to have been published in the West for the first time in 1979 with the Russian language edition of Commission member Alexander Podrabinek's book, *PUNITIVE MEDICINE*, *supra* note 80.

165. In contrast, the U.S. Administrative Procedure Act, 5 U.S.C. § 551 (1982), guarantees the availability of judicial review for all exercises of administrative discretion unless there is clear evidence of specific congressional intent to restrict access to review. Review focuses on three general issues: (1) whether the agency acted within the scope of statutory and constitutional authority; (2) whether the agency weighed all the "relevant factors" and made no "clear error of judgment;" and (3) whether the agency followed "necessary procedural requirements." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415-17 (1971).

166. In a few American jurisdictions, statutes provide for civil commitment via administrative hearing. Such hearings must conform to constitutional requirements of due process; internees have a right to judicial review. See *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1269-70 (1974) [hereinafter cited as *Civil Commitment*]. Moreover, the due process clause has been construed to require a "clear and convincing evidence" test for involuntary commitment. *Addington v. Texas*, 441 U.S. 418 (1979).

167. R.S.F.S.R. Civ. CODE art. 15. See also Kholodkovskaia, *Forensic Psychiatric Expert Examination in Civil Proceedings: Problems of Incompetence of the Mentally Ill*, in *FORENSIC PSYCHIATRY*, *supra* note 123, at 86.

under the Soviet Constitution, civil commitment of the mentally ill ought to be subject to judicial review.¹⁶⁸ He cites a constitutional provision that guarantees “inviolability of the person” and bars arrest unless approved by a court or a procurator.¹⁶⁹ Noting that judicial proceedings are necessary to declare a person legally incompetent, he argues that, a fortiori, they ought to be required in all cases of involuntary psychiatric commitment “since this involves a limitation ‘not just of civil law competence but also on individual freedom’.”¹⁷⁰ This, Malein observes, would bring procedures for involuntary civil commitment into line with statutory provisions that require judicial approval for criminal commitment.¹⁷¹

Malein’s constitutional reasoning is flawed. Statutory requirements that a court approve criminal commitments and findings of legal incompetence suggest that treating civil commitment as a purely administrative matter is inconsistent *policy*, but they are a weak basis for constitutional interpretation. Nonetheless, Malein’s argument points to the large gap in “socialist legality” left by the failure of the post-Stalinist reformers to enact a system of administrative procedure and judicial review of administrative action. Within this gap, the Soviet machinery of civil commitment is legally free to detain citizens with a potentially Stalinist arbitrariness.¹⁷²

1. Criteria for Civil Commitment

Despite the lack of constitutional or statutory guidelines, the agencies that operate the machinery of civil commitment—the U.S.S.R. and Union Republic Ministries of Public Health, in conjunction with the Procuracy, the Ministry of Internal Affairs, and the KGB—have generally not acted with Stalinist arbitrariness. The 1971 directive sets forth

168. Barry, *supra* note 159, at 18 (citing Malein’s article in a Soviet journal).

169. KONSTITUSII. art. 54 (U.S.S.R.) (“No one may be subjected to arrest other than on the basis of a judicial decision or with the sanction of a procurator.”).

170. Barry, *supra* note 159, at 18 (quoting Malein).

171. *Id.*

172. Soviet officials involved in administrative civil commitment have justified the absence of judicial review primarily by contending that Ministry of Public Health oversight is sufficient to ensure that commitment criteria and procedures are properly applied. PUBLIC HEALTH SERVICE, NATIONAL INSTITUTE OF MENTAL HEALTH, PUB. NO. 1893, SPECIAL REPORT: THE FIRST U.S. MISSION ON MENTAL HEALTH TO THE U.S.S.R. 94 (1969) [hereinafter cited as NIMH Special Report]. But as Judge Bazelon has observed, bureaucratic self-scrutiny tends to be less than aggressively critical in any political context. *Id.* at 94-95. The Soviets also argue that the system is fair because psychiatrists have no non-medical incentives and that a person’s relatives and peers would object to any mistaken commitment. *Id.* at 94. This argument, however, ignores the inevitably political content of judgments about mental illness and its hazards, as well as the deep-seated cultural and ideological bias against challenging State authority.

criteria that have been sharply criticized for their vagueness.¹⁷³ Yet these criteria are actually more specific than the brief tests, characteristic of American civil commitment statutes, that typically focus on mental illness, grave disability, and physical dangerousness to self or others.¹⁷⁴

The 1971 directive opens with a call for "urgent hospitalization" of any person "mentally ill" and "dangerous to society or to himself."¹⁷⁵ Western and Soviet dissident critics have condemned the criterion of social dangerousness as deviously ambiguous.¹⁷⁶ In the peculiar context of Soviet social life, however, it has come to have a discernible meaning, inclusive of not only physical dangerousness but also an active propensity to challenge State authority or to express ideas not officially acceptable.¹⁷⁷ That such tendencies are treated as threats to society may offend the liberal sensibility, for which such challenges are symptoms of a robust political and social life. But unsavoriness is not the same as vagueness. Within the anti-pluralist Soviet cultural and ideological environment, the criterion of social dangerousness is capable of principled application.¹⁷⁸

Unlike American civil commitment statutes, the 1971 Soviet directive lists in some detail the psychiatric conditions held to pose a "danger to society."¹⁷⁹ Six categories of illness are set forth. The category relevant for cases of political dissent specifies "hypochondriac delirious conditions, which cause the patient's incorrect aggressive behavior toward certain persons, organizations and institutions."¹⁸⁰ The directive also

173. See, e.g., AMNESTY INTERNATIONAL, *supra* note 1, at 5 (citing psychiatrists' criticism of the criteria as obscure and medically imprecise).

174. See *Civil Commitment*, *supra* note 166, at 1201-07 (discussion of American involuntary commitment standards).

175. Instruction on Hospitalization, *supra* note 162, at 195.

176. See S. BLOCH & P. REDDAWAY, *supra* note 5; V. NEKIPELOV, *supra* note 104.

177. Cf. Reich, *The World of Soviet Psychiatry*, N.Y. Times, Jan. 30, 1983, § 6 (Magazine), at 25 ("because of the nature of political life in the Soviet Union and the social perceptions fashioned by that life, dissenting behavior really does seem strange there").

178. By "principled" I mean here merely a discernible rule, precise enough to direct a decision when applied to a particular situation, irrespective of whether we believe the decision or the principle to be just.

179. In this respect, the 1971 directive differs from a 1961 edict that it replaced. The earlier directive listed four classes of illness, but added that these "are not exhaustive . . . merely an enumeration of the socially dangerous conditions which occur most frequently." Urgent Hospitalization of the Socially Dangerous Mentally Ill, Oct. 10, 1961, Instruction from the USSR Ministry of Public Health, *reprinted in* A. PODRABINEK, *supra* note 80, at 200. The 1971 instruction restructured these categories, adding explicit mention of suicidal tendencies and manic and depressive conditions, along with more detailed specification of psychotic symptoms and mention of organic brain damage. It also eliminated the open-ended statement that the listed conditions "are not exhaustive." After 1971, apparently, psychiatrists ordering commitments were required to diagnose a listed condition. Instruction on Hospitalization, *supra* note 162, at 195.

180. Instruction on Hospitalization, *supra* note 162, at 195. The 1971 instruction substituted the term "behavior" for the word "attitude" in an otherwise identical category set out in

cautions darkly that these conditions “may be accompanied by outwardly correct behavior and dissimulation.” “[E]xtreme caution,” the document warns, is therefore required “in evaluating the mental condition of such persons in order to prevent socially dangerous acts by the mentally ill through timely hospitalization without broadening the indications for urgent hospitalization.”¹⁸¹

The message to psychiatrists is clear. “Behavior” that challenges individuals and institutions in authority is, per se, a sign of socially dangerous mental disturbance. If faced with a “clinical” history of such behavior, psychiatrists are to remain scrupulously sensitive to the possibility that an examinee’s seeming normality during an interview may veil a propensity to mount such challenges in the future. When in doubt, the directive suggests, doctors are to err in favor of preventive detention. In short, Soviet criteria for civil commitment invite an administrative end run around the criminal law reforms of the Khrushchev era, in service of political repression.

2. Procedures for Civil Commitment

The administrative mechanism of civil commitment further facilitates this end run around the criminal law. Security organs, including the KGB, frequently initiate the commitment process by contacting psychiatric clinics to ask that persons be examined.¹⁸² These authorities also supply “clinical” evidence. This has included letters written to government agencies, applications for permission to emigrate, evidence of public statements deemed anti-Soviet, and banned literature allegedly circulated by an examinee.¹⁸³ To order an initial (urgent) commitment, a

the 1961 version, see A. PODRABINEK, *supra* note 80, at 200. The change perhaps reflects some level of official awareness that subjective commitment criteria are a threat to “socialist legality.”

181. Instruction on Hospitalization, *supra* note 162, at 196. This warning seems curiously inconsistent with another provision of the directive:

In cases where socially dangerous behavior of a person leads to suspicion of a mental disorder which is not apparent, such a person is not subject to urgent hospitalization. These persons, if detained in connection with socially dangerous behavior by the appropriate agencies, are subject to psychiatric examination as established by criminal procedure.

Id. at 196. The latter provision—not included in the 1961 version, see A. PODRABINEK, *supra* note 80—appears to reflect an awareness of civil commitment’s vulnerability to lawless use as a means for Stalin-style administrative internment, circumventing the Khrushchev-era reformation of Soviet criminal law. See *supra* text accompanying notes 69-77. The tension between this provision and the former warning is not resolved elsewhere in the document; thus the result is an incoherence of conflicting aims.

182. See, e.g., S. BLOCH & P. REDDAWAY, *supra* note 5, at 161-62 (KGB requested psychiatric examination of religious dissident Gennady Shimanov); cf. M. Field, *supra* note 47, at 3-4 (asserting that security organs “suggest” to psychiatric institutions that persons be committed).

183. See M. Field, *supra* note 47, at 4.

psychiatrist (or general physician in localities without psychiatric institutions) need only "provide a detailed explanation of medical and social indications for urgent hospitalization."¹⁸⁴ Paramedical workers, along with MVD security personnel, are then authorized to execute the commitment over the resistance of the patient or others.

Within twenty-four hours, a commission of three psychiatrists is supposed to examine the patient to determine "the appropriateness of the hospitalization" and "whether further stay at the hospital is necessary."¹⁸⁵ Within twenty-four hours of this examination, the patient's closest relatives are supposed to be informed of the hospitalization.¹⁸⁶ But according to Amnesty International, breaches of these requirements are common.¹⁸⁷ Relatives are frequently not notified within the required period and, in many cases, psychiatric commissions have failed to examine dissenters within a day of the initial detention.¹⁸⁸ The authorities have seized individuals on the streets or at their places of work and interned them without even an initial psychiatric examination.¹⁸⁹ In the case of the celebrated biologist Zhores Medvedev, authorities resorted to a series of almost comic ruses to lure their "patient" into a "voluntary" psychiatric exam.¹⁹⁰

Once committed, patients must be reexamined at least once a month by a commission of three psychiatrists. Discharge is conditioned upon: (1) elimination of the patient's "danger to society" and (2) agreement of relatives or a guardian to be "responsible for his care."¹⁹¹ More invidiously, the 1971 directive provides that before discharge the hospital must inform a central "psychoneurological center where all such patients must be specifically registered and subject to systematic treatment if necessary."¹⁹² This central registry, from which an ex-internee has no means

184. Instruction on Hospitalization, *supra* note 162, at 196-97. This procedure is substantially similar to typical urgent commitment procedures in the U.S.

185. *Id.* at 197.

186. *Id.*

187. AMNESTY INTERNATIONAL, *supra* note 1, at 5.

188. *Id.*

189. *Id.*

190. These included a home visit by a psychiatrist who purported to be a school official concerned over the behavior of Medvedev's son. According to Medvedev, the "official" asked detailed questions about his family; later, after three policemen and a psychiatrist had seized Medvedev from his apartment, another psychiatrist revealed that his commitment was based on the diagnosis reached by this doctor-in-disguise. S. BLOCH & P. REDDAWAY, *supra* note 5, at 172-75. Medvedev was eventually examined by a visiting psychiatric panel that included two doctors from the Serbsky. He was given the diagnosis of "sluggish schizophrenia" with "paranoid delusions of reforming society" and was held for 19 days. *Id.* at 173-81.

191. Instruction on Hospitalization, *supra* note 162, at 197.

192. *Id.*

to get his name removed, facilitates close monitoring of dissenters' activities, rendering them especially vulnerable to successive internments.¹⁹³ Moreover, like persons released from criminal commitment, they may be prophylactically interned during high-profile public events.¹⁹⁴

In no known case has a dissenter, confined via the civil commitment route, been allowed access to a lawyer.¹⁹⁵ The directive confers no such right. Nor does the directive articulate any other patients' rights. The only provision in the document for enforcement of its few procedural requirements is the statement that "[c]hief physicians of psychiatric institutions must exercise systematic supervision of compliance"¹⁹⁶ Without even an administrative procedure for patients (or families) to appeal the decisions made about their lives, this call for bureaucratic self-policing¹⁹⁷ provides patients with tenuous protection. Soviet civil commitment procedures, in short, leave mental health and security authorities remarkably free to confine citizens without heed to even the limited conception of due process reflected in Soviet criminal procedure.

IV. Dissent as Disease: The Evolution of Psychiatric Theory in the Soviet Union

The criminal and administrative law of involuntary psychiatric confinement in the post-Stalinist era has created room for the separate emergence of an approach to forensic diagnosis that lends an enticing scientific validity to the conceptualization of dissent as disease. It is a peculiar irony that the diagnostic system Soviet doctors invoke today to commit dissenters to psychiatric wards rests ultimately upon a Darwinian premise of genetic doom. The radical environmentalism of Pavlov, along with its symbolic force as a justification for the political authority of Soviet psychiatry, still retains its hold on Soviet psychotherapy. But it exists now in an uneasy relationship with a bleaker, biological model of deviant behavior. Western critics of Soviet psychiatry generally dismiss this model as a pseudosystem, consciously and cynically crafted to rationalize totalitarian repression.¹⁹⁸ There is, however, ample basis to believe that this model has played a genuine and powerful role in the Soviet view

193. AMNESTY INTERNATIONAL, *supra* note 1, at 6.

194. See S. BLOCH & P. REDDAWAY, *supra* note 5, at 101-02.

195. AMNESTY INTERNATIONAL, *supra* note 1, at 5-6.

196. Instruction on Hospitalization, *supra* note 162, at 197.

197. See NIMH Special Report, *supra* note 172, at 94-96 (rejection of Soviet claim that such self-policing suffices to prevent abuses).

198. See *supra* note 12.

of dissent as disease. An exploration of this role is essential to an understanding of why clinicians in the Soviet Union systematically do things abhorrent to most of their colleagues elsewhere.

A. *A Genetic Theory Emerges: The Snezhnevsky System*

The great strength of the triumphant Pavlovian theory of the early 1950's was its promise of infinite behavioral plasticity—a promise that affirmed Marx's hopeful premise that all social ills were the product of class exploitation and would thus wither away with the emergence of socialism.¹⁹⁹ Armed with Pavlovian therapeutic technology, psychiatrists could actively aid in this withering away—they could be Leninist agents of revolutionary change. But the Pavlovian model offered little to explain the persistence of social ills in the face of sustained Leninist social action. During the early post-Stalin years, this deficiency became more palpable.

1. Politics and Psychopharmacology

The official Soviet rhetoric of the Khrushchev period reflected an idealistic focus on socialist construction which has not since been duplicated. Yet the common ills of Soviet life did not seem to wither away with successive reforms. Street crime, petty corruption, and alcoholism continued to fester. Despite earlier claims that mental illness was vanishing,²⁰⁰ psychiatric problems, including schizophrenia, did not simply disappear. Thus, by the late 1950's, the Pavlovian gloss on the traditional explanation—socially undesirable “conditioning” due to lingering, pre-revolutionary imperialist and capitalist influences—seemed tarnished by age: Had not forty years of “socialist construction” been enough to eliminate these influences? The Pavlovian paradigm retained a limited power to “explain” special cases. Some dissidents had been reared in families “contaminated” by foreign influences (e.g., parents who had lived abroad), while others grew up in environments tainted by the lingering Soviet dilemma of religious faith. But where such environmental contamination could not be found, Pavlovian explanations seemed disturbingly inadequate.

Within this political context, Soviet psychiatrists began to assimilate some remarkable Western developments in pharmacology. In 1950, a French chemist searching for agents to potentiate the effects of surgical anesthesia synthesized the drug chlorpromazine.²⁰¹ Two years later,

199. See *supra* notes 61-62 and accompanying text.

200. See, e.g., *supra* note 62 (1952 claim that schizophrenia had been eradicated).

201. Byck, *Drugs and the Treatment of Psychiatric Disorders*, in *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 152, 157 (L. Goodman & A. Gilman 5th ed. 1975).

French clinical researchers announced that they had administered this drug to mental patients and had achieved amelioration of psychotic symptoms (delusions and hallucinations).²⁰² A burst of psychopharmacological research over the next several years confirmed chlorpromazine's efficacy as a treatment for the symptoms of schizophrenia and other psychoses.²⁰³ Other antipsychotic drugs, including haloperidol,²⁰⁴ were synthesized and tested with dramatic results. This psychopharmacological revolution made all other approaches to the treatment of psychotic disease suddenly seem obsolete. In the Soviet Union as in the West, psychiatrists once burdened by an inability to better the lot of legions of psychotic patients rapidly and broadly applied the new therapies.

The psychopharmacological revolution of the 1950's had a different significance for the development of a diagnostic approach to dissent. To many research psychiatrists, the bewildering psychotic symptoms and personality traits of schizophrenics, considered by various schools as primarily the consequence of an aberrant early childhood, a disturbed family environment,²⁰⁵ or a diseased social structure,²⁰⁶ seemed abruptly recast as a biochemical mystery.²⁰⁷ In the late 1950's and early 1960's, some of these researchers raised the question of a genetic predisposition to schizophrenia. They scrutinized data reported by proponents of various environmental etiologies²⁰⁸ and suggested that genetic hypotheses could also explain these results. They pointed to earlier evidence of a direct relationship between the genetic closeness of relatives and concordant incidence of schizophrenia,²⁰⁹ and began an expanded program of research.

During the late 1950's, genetic approaches to schizophrenia made little official headway within Soviet psychiatry. Until the defrocking of Lysenko in the early 1960's, an intense animosity toward hereditarian

202. *See id.*

203. *See id.*

204. *Id.* at 153.

205. *See, e.g.,* Lidz, *Schizophrenia and the Family*, 21 PSYCHIATRY 21, 24 (1958).

206. *See, e.g.,* the Marxist-Pavlovian approach. *See also* Hollingshead & Redlich, *Social Stratification and Schizophrenia*, 19 AM. SOC. REV. 302 (1954) (schizophrenia much more prevalent in lower than in upper classes, implying etiologic role of lower class environment).

207. *See, e.g.,* Kety, *Biochemical Theories of Schizophrenia* (Pt. I), 129 SCIENCE 1528 (1959); Kety, *Biochemical Theories of Schizophrenia* (Pt. II), *supra*, at 1590.

208. *See, e.g.,* Hollingshead & Redlich, *supra* note 206.

209. *See, e.g.,* F. KALLMANN, *HEREDITY IN HEALTH AND MENTAL DISORDER: PRINCIPLES OF PSYCHIATRIC GENETICS IN THE LIGHT OF COMPARATIVE TWIN STUDIES* (1953). Even before the advent of antipsychotic drugs, genetic approaches to schizophrenia had been urged, though they received relatively little attention. *See* Kallmann, *The Genetic Theory of Schizophrenia*, 103 AM. J. PSYCHIATRY 309 (1946).

ideas permeated the Soviet scientific establishment.²¹⁰ Yet many scientists remained quietly aware of Lysenkoism's great cost to progress in agriculture and other biological fields. And the Lysenkoists apparently made no effort to restrain the wide use of antipsychotic drugs. Soviet psychiatrists continued to pay homage to Pavlov. But the success of drug treatment for schizophrenia, along with the inability of Pavlovian theory to explain the persistence of a myriad of social ills, suggested that the Pavlovian paradigm alone was inadequate. Since this paradigm was the scientific incarnation of the Marxist dream that all social ills would wither away with the creation of socialism, this inadequacy had a fundamental political significance.

The Soviet leadership sensed this problem. In 1959, Khrushchev signaled a radical revision of the Marxist-Leninist line on the social origins of all deviant behavior. Certain "offenses," he proclaimed, were the product not of class tension and exploitation but of "abnormal minds."²¹¹ "Can there be diseases, nervous disorders among certain people in the Communist society?" he asked. "Evidently there can be. . . . To those who might start calling for opposition to Communism on this 'basis,' we can say that now, too, there are people who fight against Communism . . . but clearly the mental state of such people is not normal."²¹² This frequently quoted comment contained an implicit premise that political dissent was merely a sign of hereditary taint. If Lysenko did not then suspect his ultimate fate, he surely ought to have. A few years later, the inevitable occurred, and Soviet psychiatrists were free to follow Khrushchev's signal to devise hereditarian explanations for all sorts of unwanted behavior.

2. Cues from the West: "Genetic Spectrum" Models of Schizophrenia

Meanwhile, Western researchers were reporting results that substantially strengthened the case for a genetic predisposition to schizophrenia.²¹³ From these studies, designed to examine genetic factors isolated from environmental circumstances, some Western enthusiasts of the

210. See generally Z. MEDVEDEV, *THE RISE AND FALL OF T. D. LYSENKO* (1969).

211. S. BLOCH & P. REDDAWAY, *supra* note 5, at 62 (quoting from May 24, 1959 Pravda report).

212. *Id.*

213. A series of studies done in the United States, Europe, and Japan during the early and middle 1960's demonstrated a much higher incidence of the disease in identical than in fraternal twins of schizophrenics. See J. PINCUS & G. TUCKER, *BEHAVIORAL NEUROLOGY* 102-03 (2d ed. 1978). Identical (monozygotic) twins share virtually all their genetic material, while fraternal (dizygotic) twins share only 25%, no more than other siblings. A study of adults born to schizophrenic mothers but permanently separated from them during the first few days of life (and placed in foster homes) revealed a significantly higher incidence of the disease in these subjects than in controls who had been separated from nonschizophrenic mothers within

hereditarian hypothesis concluded flatly that schizophrenia is a "genetic disease."²¹⁴ Such studies, two reviewers proclaimed, "offer no support for the view that the psychosocial environment plays any role in determining the risk of developing schizophrenia in individuals who are, genetically, at high risk."²¹⁵

In fact, the data were hardly so unequivocal. Critics of the genetic hypothesis could point to lingering environmental influences that the studies had failed to factor out.²¹⁶ In addition, the fact that schizophrenia concordance rates for identical (monozygotic) twins were nowhere near one hundred percent strongly suggested that psychosocial factors were somehow involved.²¹⁷ A more restrained assessment was offered by another reviewer in 1975. "These genetic studies," he concluded, "now provide strong but not conclusive evidence for a biological substrate of schizophrenia."²¹⁸

Yet the entrepreneurs of a new science of psychogenetics went further. They debated the competitive merits of polygenic and single gene theories, and they speculated on the combined phenotypic effects of genes for schizophrenia and for "personality, adaptability, and other functions."²¹⁹ Moreover, they attempted to apply these etiologic notions to rationalize the confusing world of psychiatric diagnosis.

Psychiatrists have long sensed, from their clinical experience, some rough similarities between the cognitive, emotional, and behavioral qualities of patients carrying the diagnosis of schizophrenia and of persons believed to possess a variety of less severe disorders. The official diagnostic manual of the American Psychiatric Association (APA) declares that schizophrenics suffer from "characteristic disturbances" in "content and form of thought, perception, affect, sense of self, volition, relationship to

a few days of birth. Heston, *Psychiatric Disorders in Foster Home Reared Children of Schizophrenic Mothers*, 112 *BRIT. J. PSYCHIATRY* 819 (1966). Moreover, other serious psychiatric problems, including personality disorders and alcoholism, were reportedly much more common in the former group. *Id.* at 824.

214. J. PINCUS & G. TUCKER, *supra* note 213, at 106.

215. *Id.*

216. These environmental influences included: (1) the possibility of a much greater similarity between the childhood experiences of identical twins than of fraternal twins; (2) early post-natal environmental experiences (before foster home or adoptive placement); and (3) a systematic difference between foster home (or adoptive) placements for infants who did and did not eventually develop schizophrenia (such a difference could have resulted from socioeconomic or other differences among natural mothers).

217. Based on flimsy evidence—and a dubiously relevant analogy with epilepsy—Pincus and Tucker attempt to explain this discrepancy by asserting that some "acquired brain damage" during pregnancy or early childhood may be necessary for "full expression of the gene." J. PINCUS & G. TUCKER, *supra* note 213, at 106-07.

218. Byck, *supra* note 201, at 155.

219. See J. PINCUS & G. TUCKER, *supra* note 213, at 107; see also E. SLATER & V. COWIE, *THE GENETICS OF MENTAL DISORDERS* (1971) (analyzing genetic theories about the etiology of various psychiatric illnesses).

the external world, and psychomotor behavior," but cautions that "no single feature is invariably present or seen only in Schizophrenia."²²⁰ Frankly psychotic symptoms—delusions and hallucinations—pose the diagnostic problem of distinguishing between schizophrenia and other severe, disabling psychoses.²²¹ But other qualities of schizophrenia (blunted emotional expressiveness; social withdrawal or isolation; "metaphorical," "overelaborate," or "digressive" speech; "odd or bizarre ideation;" "superstitiousness;" "magical thinking;" "overvalued ideas;" and paranoid delusions)²²² blend seamlessly with signs of common, psychiatrically defined personality disorders²²³ and with anti-social, creative, stubborn, or reflective quirks of character that even most psychiatrists would acknowledge as normal.²²⁴

The psychogeneticists pointed to this continuum and purported to explain it. They proposed a genetic "spectrum" of schizophrenic and related disorders:²²⁵ a "continuum from . . . schizophrenia to personality disorder, alcoholism, eccentricity, and even talent"²²⁶ The concept has a tempting elegance. It is, in the words of one of its critics, Walter Reich,

particularly attractive . . . from a theoretical point of view, since it provides not only a relatively parsimonious and unifying etiological theory,

220. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 182 (3d ed. 1980) [hereinafter cited as DSM-III].

221. DSM-III diagnostic classifications for psychotic symptoms include Schizoaffective and Schizophreniform Disorders as well as Brief Reactive Psychosis. See *id.* at 181-93, 199-203. These classifications are overlapping and, according to critics, quite arbitrary. They represent an attempt to organize psychotic processes into discrete diagnostic groups in the absence of a "known etiology or pathophysiological process." *Id.* at 7.

222. *Id.* at 189-91.

223. These include, among others, the Paranoid, Schizoid, Schizotypal, Avoidant, and Antisocial Personality Disorders. *Id.* at 305-30.

224. Even beliefs that psychiatrists analyze as delusional in some settings are not interpreted as psychotic dysfunction. The classic example is religious conviction, which alleviates distress, one psychiatrist writes, by altering reality. It is a "wish-fulfilling delusion" that may yield "sustained feelings of delusional superiority or entitlement." With faith that "'Jesus lives inside of me and answers all my prayers,' . . . unpleasant feelings are replaced with their opposites." The result "can be highly adaptive." G. VAILLANT, *supra* note 36, at 383. But what is the difference, psychologically, between "Jesus lives inside of me and answers all my prayers," and "I am Jesus?" Conventional psychodynamic psychiatry suggests no psychodynamic distinction. According to the APA's DSM-III, religious faith is not a delusion only because a belief, to be delusory, must be one not "ordinarily accepted by other members of the person's culture or subculture." DSM-III, *supra* note 220, at 356. As it did with the issue of whether homosexuality is a disease, the APA settled the matter by majority vote. Thus, according to APA diagnostic criteria, religious faith, in a society of committed, atheistic Marxists, is a symptom of psychotic disease.

225. See Kety, Rosenthal, Wender & Schulsinger, *The Types and Prevalence of Mental Illness in the Biological and Adoptive Families of Adopted Schizophrenics*, in THE TRANSMISSION OF SCHIZOPHRENIA 345 (D. Rosenthal & S. Kety eds. 1968).

226. Eisenberg, *The Interaction of Biological and Experiential Factors in Schizophrenia*, in THE TRANSMISSION OF SCHIZOPHRENIA, *supra* note 225, at 40 (critique of genetic spectrum theories).

but, also, through its research, a method of delimiting the outer boundaries of the genetic spectrum, and of testing whether or not specific clinical states hypothesized as lying within those boundaries do in fact do so.²²⁷

Yet this reach toward outer genetic boundaries poses potentially unbounded dangers when the spectrum concept is applied to diagnostic practice.²²⁸ It invites a dramatic expansion of the *clinical* idea of schizophrenia beyond frank psychosis to personality deviations²²⁹ and even normality. Indeed, some have argued that certain normal thought processes are phenomenologically schizophrenic, and, during periods of stress, these processes may briefly become so prominent that differentiation from schizophrenic psychosis becomes difficult.²³⁰ The spectrum concept could render such differentiation unnecessary.

In the abstract, a genetically grounded widening of the concept of schizophrenia does not per se pose a danger. But in the real world context of clinical diagnosis, there are several hazards. First, in general, genetic theories nurture therapeutic and political abdication. While a bleak outlook may be justified for the classic schizophrenic psychosis,²³¹ the spectrum concept's focus on genetic explanation for many non-psychotic mental styles encourages unwarranted therapeutic nihilism.²³² More broadly, it suggests (perhaps reassuringly, but also inaccurately) that neither a society nor its "afflicted" individuals are responsible for these styles or their social consequences. Second, the debilitating labeling effects of a schizophrenic diagnosis,²³³ shackled to its bearer by chains of genetic inevitability, are extended to the eccentric, the mildly troubled, and the talented²³⁴ by virtue not of demonstrably profound disability but by virtue of a hypothetical vulnerability. Diagnosis, as Reich notes, is not merely an act of scientific classification; it is "an act of clinical intervention."²³⁵ Diagnosis has a myriad of non-clinical implications. It affects a person's legal status, economic opportunities, social standing, and self-image, as well as the credibility of her ideas. Third, the spectrum concept invites an invidious form of clinical distortion. Research diagnosticians, as Reich notes, are deliberately kept blind as to their subjects'

227. Reich, *The Spectrum Concept of Schizophrenia: Problems for Diagnostic Practice*, 32 ARCHIVES GEN. PSYCHIATRY 489, 490 (1975).

228. *Id.* at 490-92.

229. Reich cites several American studies reporting up to 15% incidence of personality deviations that are candidates for inclusion in a proposed genetic spectra. *Id.* at 491.

230. *Id.*

231. *Id.* at 490.

232. *See id.* (pessimism less justifiable for non-psychotic disease entities on schizophrenic spectrum).

233. *Id.* at 490-91.

234. *See supra* text accompanying note 226.

235. Reich, *supra* note 227, at 492.

family psychiatric histories; this assures that their diagnostic judgments—intended to *test* genetic hypotheses—will not be biased by awareness of psychiatrically troubled relatives. In clinical practice, though, a diagnostician knows the patient's family history. If the doctor adheres to the spectrum paradigm, awareness of even mild psychopathology in some distant relative may encourage her to interpret slight personal quirks as spectrum symptomatology.²³⁶

3. The Soviet Enshrinement of a Spectrum Theory

The genetic spectrum paradigm has remained largely a research concept in the West. Sensitivity to the moral hazards discussed above, the persistence of environmental explanations,²³⁷ and the absence of compelling neurophysiological or biochemical evidence in favor of genetic hypotheses have restrained most psychiatrists from translating spectrum theory into practice. Western psychiatric pluralism, so frustrating for many who criticize the proliferation of conflicting paradigms, has not permitted the enshrinement of any etiologic theory as the basis for diagnostic practice.²³⁸

The story has been much different in the Soviet Union. After Khrushchev signaled in 1959 that hereditarian explanations for social deviance would be politically welcome,²³⁹ psychiatrists had to wait several years, until the fall of Lysenko, to safely pursue genetic inquiries.²⁴⁰ But they made up for their late start with the enthusiasm of recent converts.

a. *The Political Triumph of Andrei Snezhnevsky*

The leading enthusiast of the genetic spectrum theory in the Soviet Union was schizophrenia researcher Andrei V. Snezhnevsky. Snezhnevsky had climbed rapidly through the most prestigious ranks of Soviet psychiatry during the 1940's and 1950's.²⁴¹ He was, in Reich's less-than-complimentary words,

a prototypical product of Stalinist and post-Stalinist Soviet life . . . capable of surviving shifts and feints in theory and power and of coming out on top while others less skilled than he in organizational maneuvering or in sensing

236. *Id.* at 491.

237. See, e.g., T. LIDZ, *THE ORIGIN AND TREATMENT OF SCHIZOPHRENIC DISORDERS* (1973) (schizophrenogenic family theory).

238. The dominant American diagnostic system explicitly disavows reliance upon any theory of etiology or pathogenesis. See *supra* note 221.

239. See *supra* text accompanying notes 211-12.

240. See *supra* text accompanying notes 212-14.

241. Reich, *Psychiatric Diagnosis as an Ethical Problem*, in *PSYCHIATRIC ETHICS* 66 (S. Bloch & P. Chodoff eds. 1981).

the most advantageous political and ideological loyalties—less skilled than he or more principled—lost prominence or found themselves denounced, purged, or worse.²⁴²

In 1962, Snezhnevsky was named to Soviet psychiatry's loftiest post, Director of the Institute of Psychiatry of the Academy of Medical Sciences.²⁴³ In an ironic twist on Lysenkoism, Snezhnevsky aggressively used his power to promulgate a genetic spectrum theory of schizophrenic illness and to assure its almost uniform nationwide application in clinical and forensic practice. He did this not by crude coercion, but by deftly using the highly centralized authority of his post to shape the content of publications and teaching programs, to channel research and training funds, and to bestow or withhold other academic opportunities and honors.²⁴⁴ His methods were akin to those of an entrepreneurial American university department chairman,²⁴⁵ but the domain of his authority was nationwide and officially sanctioned by the State. By the middle 1970's, according to Walter Reich, the Snezhnevsky system had become the standard Soviet approach to the diagnosis of schizophrenia and many other purportedly related classes of psychopathology.²⁴⁶

b. *The Snezhnevsky Spectrum Theory*

Snezhnevsky's theory itself is not nearly as remarkable as his political triumph. He was a latecomer to research on the question of a genetic basis for schizophrenia, and his spectrum model drew its essence from Western theories.²⁴⁷ Snezhnevsky's basic notion is that schizophrenias are divisible into three genetically distinct *forms*. Within each form lies a

242. Reich, *supra* note 139, at 34-35.

243. Reich, *supra* note 241, at 66.

244. For example, Snezhnevsky edited the nation's only psychiatric journal, the *Korsakov Journal of Neuropathology and Psychiatry*. In the 1940's and 1950's, he selected and trained numerous eventual leaders of Soviet psychiatry during his tenure as a faculty member and then as chairman of the Department of Psychiatry of the Central Postgraduate Medical Institute, the nation's most prestigious center for advanced research training. This position also allowed him to influence government ministries' allocations of resources for psychiatric research and education. Reich, *supra* note 241, at 66. Moreover, Snezhnevsky exercised firm guidance over the Serbsky Institute, which has administrative authority over forensic psychiatric examination throughout the Soviet Union. See *Instruction on Forensic Psychiatric Examination*, *supra* note 97, at 203-08. He won genuine commitment to the validity of his hereditarian theory from many colleagues and students, including some who later emigrated. Reich, *supra* note 139, at 35.

245. See L. VEYSEY, THE EMERGENCE OF THE AMERICAN UNIVERSITY 317-32 (1965) (chairmen's use of powers of appointment, promotion, and publication to build disciplines in their images, demanding loyalty and suppressing rival views).

246. Reich, *supra* note 241, at 66.

247. For Snezhnevsky's own discussion of his system, see Snezhnevsky & Vartanyan, *The Forms of Schizophrenia and Their Biological Correlates*, in BIOCHEMISTRY, SCHIZOPHRENIAS, AND AFFECTIVE ILLNESSES 1 (H. Himwich ed. 1970); Snezhnevsky, *The Symptomatology*,

wide continuum of disease severity. The severity of a patient's illness—its place on one of the three continua—may vary for many environmental reasons. But the *form* of a patient's disease is a lifelong, genetic trait—an incurable diathesis. Thus even the mildest case of a particular form is deemed capable of developing into the most malignant version.

One form, the “periodic,” is of little significance for diagnosis of dissenters. It features acute episodes of psychotic symptoms with mood swings, followed by full returns to previous levels of health. Patients fitting this classification would almost certainly be given schizophrenic or other psychotic diagnoses by most Western psychiatrists.²⁴⁸ There have been no reports of dissenters interned with this diagnosis.

More politically problematic are the “shift-like” and “continuous” forms. Persons supposedly suffering from “shift-like” disease experience acute attacks of illness from which they recover only partially, resulting in gradual deterioration over the years. Patients with the “continuous” form develop chronic symptoms at a young age and also follow a gradual downhill course. Within these two forms, Snezhnevsky separates the continua of disease intensity into mild, moderate, and severe subtypes. The moderate and severe subtypes are characterized by clearly psychotic symptoms that Western clinicians typically interpret as evidence for a schizophrenic diagnosis.

Persons purportedly suffering from the mild subtypes of “shift-like” or “continuous” schizophrenia, however, have no psychotic symptoms. These individuals would probably be diagnosed by non-Soviet practitioners not as schizophrenic, but as “neurotic, suffering from a character (personality) disorder, or even mentally well.”²⁴⁹ The mild subtype of the “shift-like” form is characterized by such features as neurotic behavior, “self-absorption,” “social contentiousness,” and “philosophical concerns”²⁵⁰—criteria that might, at worst, be suggestive of Schizoid, Avoidant, or Antisocial Personality Disorders, according to the American Psychiatric Association (APA) diagnostic scheme.²⁵¹ Similarly, the “continuous” form's mild variant (also termed “sluggish”) is characterized by “self-consciousness,” “introspectiveness,” “obsessive doubts,”

Clinical Forms, and Nosology of Schizophrenia, in *MODERN PERSPECTIVES IN WORLD PSYCHIATRY* 425 (J. Howells ed. 1971). See also Reich, *supra* note 227, at 492; Reich, *supra* note 241, at 66-70.

248. The “periodic” form corresponds roughly with several *DSM-III* psychotic diagnoses, including some of the schizophrenias, Schizoaffective Disorder, and Brief Reactive Psychosis. See *DSM-III*, *supra* note 220.

249. Reich, *supra* note 241, at 68.

250. *Id.* at 67.

251. See *supra* note 223.

conflict with authority, and reformism.²⁵² These extremely vague criteria suggest the whole range of spectrum states: from the APA's personality disorders through eccentricity to creative, robust normality.

Thus, under the Snezhnevsky system, an extraordinary range of personal styles are subject to being construed as schizophrenic disease—capable, in theory, of degenerating into psychotic dysfunction. Snezhnevsky's spectrum theory is hardly unique in this regard. The notion that these styles are schizophrenic and do reflect a risk of psychotic degeneration is common to Western spectrum theories.²⁵³ What is unique, as Reich points out, is the triumph of this theory as conventional diagnostic wisdom, virtually immune from internal criticism.²⁵⁴

Snezhnevsky and his supporters defend the wide clinical application of their spectrum system on the ground that, in contrast to Western research, their research has conclusively shown the validity of spectrum theories. Since 1962, Snezhnevsky's Institute of Psychiatry has mounted an intensive program of research into the clinical genetics of schizophrenia. Like their Western counterparts, the Institute's investigators have examined thousands of relatives of schizophrenic patients, searching for evidence of any psychiatric disorders. They have reported remarkable results: psychiatric symptoms in these examinees were almost always

252. See Reich, *supra* note 241, at 67.

253. See *supra* text accompanying notes 225-30.

254. Under the prevailing American diagnostic scheme, a schizophrenic diagnosis may be made in the absence of obviously psychotic symptoms. The APA criteria provide for such a diagnosis if a person with certain schizotypal character traits evinces, without hallucinations or delusions, "blunted, flat, or inappropriate affect" associated with "incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech." DSM-III, *supra* note 220, at 188-89. This exception to the requirement of overtly psychotic symptoms appears narrow in practice, compared to the Snezhnevsky system's. This is strongly suggested by the results of a 1972 World Health Organization (WHO) study that reviewed diagnostic criteria at centers in nine Western, Eastern bloc, and Third World nations. Diagnoses made by these centers were compared with rediagnoses made by a computer program that applied the WHO's International Classification of Diseases (ICD) criteria. See WORLD HEALTH ORGANIZATION, PUBLIC HEALTH PAPERS NO. 63, SCHIZOPHRENIA: A MULTINATIONAL STUDY (1972). Diagnoses from seven centers closely matched the ICD rediagnoses. But at Moscow's Institute of Psychiatry (Snezhnevsky's center), schizophrenia was diagnosed much more frequently than it was when the Moscow patients were rediagnosed by the ICD-based computer program. This discrepancy was due largely to the Moscow clinicians' greater tendency to classify non-psychotic patients as schizophrenic. Applying criteria from DSM III's immediate predecessor, the only American center in the study also diagnosed schizophrenia much more frequently. But this gap was due primarily to the American center's tendency to classify as schizophrenic patients who by ICD criteria fit another psychotic diagnosis. See Reich, *supra* note 227, at 493-96. Interestingly, diagnoses from the only other Eastern bloc center in the study—Prague—closely matched the ICD diagnoses.

those characteristic of their schizophrenic relatives' Snezhnevskyan disease forms. The intensity, or subtype, of afflicted relatives' illnesses varied, but the *forms* generally "bred true."²⁵⁵

This research, however, was fundamentally flawed. Unlike Western investigators, Snezhnevsky's research diagnosticians were not kept blind to the family psychiatric histories of their subjects.²⁵⁶ The psychiatrists who interviewed relatives of diagnosed schizophrenics not only knew that these examinees had family histories of the disease, but also knew the particular schizophrenic form which each subject's family member(s) purportedly had. They also were aware that their Institute's chief, who had devised and aggressively promoted the theory they were testing, was hardly impartial as to how he wanted the research to come out. Obtaining findings consistent with the spectrum theory could be crucial to getting an advanced degree or to moving further through the academic ranks.²⁵⁷ Without the protection of being blind to their subjects' family

255. Reich, *supra* note 177, at 20, 23 (discussing Snezhnevskyan clinical research).

256. See *supra* text accompanying notes 235-36.

257. The case of Etely P. Kazanetz is an illustration of the hazards of challenging Snezhnevskyan orthodoxy. Kazanetz was the holder of an advanced research degree and a prestigious appointment as a research psychiatrist at Moscow's Serbsky Institute, which is closely linked to Snezhnevsky's Institute of Psychiatry. In 1979, he published findings in an American journal that were discretely critical of Snezhnevsky's broad conception of schizophrenia. Kazanetz, *Differentiating Exogenous Illness From Schizophrenia*, 36 ARCHIVES GEN. PSYCHIATRY 740 (1979). For this bit of daring, he was abruptly dismissed from his research post. IAPUP, INFORMATION BULL. NO. 2, Oct. 1981, at 10. His subsequent professional fate is unclear.

In the study that got him into political trouble, he used a computer learning and pattern recognition program to evaluate the first psychotic episodes of more than 300 patients, most of whom carried schizophrenic diagnoses. Some of these patients had developed repeated psychotic breakdowns and worsening, schizophrenic disease. Others, including many labeled "schizophrenic," had returned quickly to health, with excellent occupational function and no major psychiatric problems; they were burdened chiefly by the legal consequences of their diagnoses. Kazanetz hypothesized that only the former group merited a genetically-based schizophrenic diagnosis. Further, the latter group's breakdowns had resulted from transient environmental stresses, emotional disorders, and physical illness. Finally, Kazanetz offered that the groups could be distinguished based on their symptoms at the time of their initial (or only) psychotic breakdowns. Along with several other psychiatrists, he reviewed follow-up records spanning up to 20 years after the patients' initial breakdowns, reclassifying the subjects (based upon pre-Snezhnevsky Soviet criteria) into two categories—"schizophrenia" and "psychosis of exogenous origin." Many of those originally diagnosed as schizophrenic had excellent long-term courses, without major psychiatric problems, and fell into the latter category. Kazanetz then compared these results with computer rediagnoses made by feeding data to his pattern recognition program from initial psychotic episodes only. For the overwhelming majority of patients, the computer rediagnoses accurately "predicted" the reclassifications based on follow-up data. Kazanetz concluded that accurate distinctions between genetically-based (schizophrenic) and environmentally-caused (exogenous) psychoses could in fact be made during a first psychotic episode, and that Snezhnevsky's "periodic" form of schizophrenia, see *supra* note 248, is actually an exogenous psychosis. Without explicitly condemning Snezhnevsky's model, Kazanetz criticized "incorrect assessment of pre-morbid personality traits," overemphasis of heredity, and inattention to environmental causes of psychosis. Moreover, he

histories, "it was just too easy for them, even if they were honest, to be swayed by their mission to prove Snezhnevsky right."²⁵⁸

4. Forensic Application of the Snezhnevsky System

Soviet forensic psychiatrists aggressively apply Snezhnevsky's broad conception of schizophrenic disease. The authoritative treatise on forensic psychiatry cautions against "erroneously" interpreting "[t]he deepening personality changes" of "slowly developing" schizophrenia ("sluggish" subtype of the "continuous" form) as "character defects."²⁵⁹ Once a schizophrenic diagnosis has been made, however—even a diagnosis of one of the "mild," non-psychotic subtypes—a finding of legal non-responsibility²⁶⁰ is almost automatic. Even if an accused appears largely normal, with "only certain morbid symptoms" that seem unrelated to her alleged "socially dangerous" act, the schizophrenic disease is deemed to have a global impact upon mental function.²⁶¹

It would be wrong to think that the morbid schizophrenic process can strike certain mental functions alone and leave others totally unaffected. . . . Those psychiatrists and jurists are in error who attempt to cast doubt on the legal irresponsibility of schizophrenics when socially dangerous actions cannot be associated with any evident psychopathology.²⁶²

Thus Snezhnevsky's spectrum hypothesis—that persons with seemingly mild disease are every bit as genetically schizophrenic as the most fulminantly psychotic patients—is transmuted into a rationale for wholesale findings of non-responsibility once a spectrum diagnosis is made. In this way, Soviet forensic psychiatrists finesse—or engulf—the causality component of the legal question of responsibility²⁶³ by the act of diagnosis.

expressed regret over the cost to "individual rights" from "incorrect" diagnoses of schizophrenia. Kazanetz, *supra*, at 741-45.

258. Reich, *supra* note 177, at 23.

259. Morozov, *Schizophrenia*, in FORENSIC PSYCHIATRY, *supra* note 123, at 197, 223.

260. Such a finding also includes incompetence to stand trial. See *supra* text accompanying note 94.

261. Morozov, *supra* note 259, at 221-22.

262. *Id.* Even during "prolonged and persistent remissions," schizophrenics are generally to be found criminally non-responsible. Exceptions may be made only where "personality changes are so slight that they do not interfere with the person's adaptability," although "prolonged and persistent remissions without notable personality changes are comparatively rare." *Id.* at 225. Since dissent in the Soviet Union by its very nature interferes with a person's "adaptability," this exception is extremely unlikely to be invoked for dissidents.

263. See *supra* text accompanying notes 88-93.

B. *An Older Diagnostic Construct: Paranoid Psychopathy*

1. Value-Laden Theory

Existing in an uncertain relation to the mild subtypes of schizophrenia is the older Soviet diagnosis of "paranoid psychopathy," which is also conferred upon dissenters.²⁶⁴ In contrast to the Snezhnevskyan schizophrenias, the psychopathies are said to be caused by both genetic and environmental influences; either may predominate in a particular case.²⁶⁵ Unlike the schizophrenias, they supposedly leave the intellect intact, distorting only the emotional aspects of personality.²⁶⁶ Soviet psychiatrists distinguish the psychopathies from normal variants of personality on the vague ground that only the former involve "relatively permanent and deeply penetrating anomalous variants"²⁶⁷ which "hinder . . . adaptation of the person to his environment."²⁶⁸

Paranoid psychopaths are said by the official treatise on forensic psychiatry to be marked by their "unflagging conviction."²⁶⁹ "They frequently exaggerate their importance and believe that others are paying attention to them;" this can adversely influence other persons, "especially if these persons are especially suggestible."²⁷⁰ They sometimes "have a passion for scientific invention and reformist work" and are "convinced of their righteousness."²⁷¹ But their "projects and plans usually reveal the narrow range of their interests and knowledge, besides their erroneous nature."²⁷² According to the dissident psychiatrist Semyon Gluzman, the ambiguous concept of paranoid psychopathy involves, in essence, a developmental process that begins with an "obsessive idea"—a preoccupation with some goal.²⁷³ As the preoccupied person meets resistance, his obsession becomes an "over-valued idea . . . a notion, usually rational in content . . . the importance of which has

264. See generally Bukovsky & Gluzman, *supra* note 145.

265. Kerbikov & Felinskaia, *Psychopathy*, in FORENSIC PSYCHIATRY, *supra* note 123, at 393, 394. The authors' catalogue of vaguely described causes includes virtually every possibility one might imagine: genetic or other congenital events, upbringing, other social conditioning, pubertal and senescent hormonal changes, infectious diseases, trauma, and various intoxications. *Id.* at 393-95.

266. *Id.* at 393. Thus psychopathies "are also encountered in gifted people." *Id.* at 393-94.

267. *Id.* at 393.

268. *Id.* at 394. This imprecise distinction is akin to that in American practice between personality disorders and normal personality traits: "It is only when *personality traits* are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute *Personality Disorders*." DSM-III, *supra* note 220, at 305 (emphasis in original).

269. Kerbikov & Felinskaia, *supra* note 265, at 403.

270. *Id.*

271. *Id.*

272. *Id.*

273. Bukovsky & Gluzman, *supra* note 145, at 426-27.

been overestimated beyond all reason.”²⁷⁴ The individual progresses eventually into a “delusional state,” featuring a system of “erroneous” beliefs, “incapable of alteration,” and accompanied by “persecution mania.”²⁷⁵ When forensic psychiatrists diagnose dissidents as paranoid psychopaths, they typically discern one of two related types of delusional state: “reformist delusions” (unshakable beliefs that the social system should be changed) and “litigation mania” (persistent conviction that one’s rights have been violated).²⁷⁶

From a liberal, pluralistic perspective, these characterizations of political commitment are preposterous, even comic. But even the concept of delusion is, in a limited sense, culturally relative—relative enough to render these characterizations plausible in the Soviet context. To show this, it is convenient to consider delusory notions as falling into three classes: (1) bizarre notions of fact (factual beliefs that persons maintain in the face of conclusive evidence to the contrary); (2) unreasonable notions of fact (factual beliefs maintained in the face of evidence that they are extremely unlikely to be true); and (3) notions of value (value judgments “so extreme as to defy credibility”).²⁷⁷

Notions in the first class—e.g., “little green creatures are crawling up my arms”—are clearly delusory²⁷⁸ in any social or cultural setting. But some in the second group will not be viewed as delusory in all contexts. Many religious beliefs are classic examples. In a society of committed atheists, the notion “Jesus lives inside me and answers all my prayers,” would seem delusory. In our own society, however, it does not, although available empirical evidence lends this belief no support. Whether the belief is a sign of psychosis or is consistent with robust normality is no more than a question of its social acceptability.²⁷⁹ The delusory status of some notions of value is more obviously relative. Whether a value judgment is “so extreme as to defy credibility” depends, of course, on who determines credibility. In a pluralistic society, it is difficult to imagine a political preference that might meet this test of incredibility.²⁸⁰ But in a society used to a single correct system of political belief, or in a society in which any challenge to authority is regarded with suspicion, dissenting political ideals could plausibly be thought incredible and thus delusory.

274. *Id.*

275. *Id.*

276. *Id.*

277. DSM-III, *supra* note 220, at 356.

278. Strictly speaking, a false sensory perception is a *hallucination*, while unshakable conviction that this perception is accurate is a *delusion*. *Id.*

279. See *supra* note 224.

280. We might hope, though, that some preferences—Nazi racial notions, for instance—would be thought to “defy credibility” even in a culture of democratic pluralism. Some of us would view Nazi racial ideas as delusions.

Thus, in an authoritarian political culture, "reformist delusion" is a coherent and credible psychiatric concept. So is "litigation mania," in a society where rights are authoritatively defined by those being litigated against and where the authorities' denial of a benefit to an individual is itself construed as convincing evidence that the individual's claim was untrue.²⁸¹

2. Forensic Application

Diagnosis of a psychopathy, in contrast to a schizophrenia, does not virtually always trigger a finding of criminal non-responsibility.²⁸² Because their intellectual processes are not deemed genetically aberrant,²⁸³ psychopaths are generally considered "capable of correctly evaluating external reality and governing their actions. . . ."²⁸⁴ Thus, psychopathic disorders usually do not satisfy the causality element of the legal test for criminal non-responsibility.²⁸⁵ Some poorly defined exceptions, however, are described in the official forensic psychiatry text. If "the character alterations in the psychopathic personality are so deep that a psychopathic state can justifiably be compared with a state of mental illness," the person may be found non-responsible.²⁸⁶ "Such cases usually involve asthenic [a category into which no dissenter is known to have been placed²⁸⁷] and paranoid psychopaths."²⁸⁸ Moreover, if the accused acted "in a state of deep decompensation or acute psychopathic reaction," a finding of non-responsibility finding may be required.²⁸⁹

These vague criteria can hardly provide forensic examiners with genuine guidance. They invite psychiatrists to make their own "gut" judgments about responsibility and then to bury these judgments beneath a technical-sounding formulation of how some pathologic processes did or did not cause a criminal act. A dissident who brazenly hoisted a picket

281. In such a society, a fortiori, an individual's conviction that political change is called for, or that her rights have been violated, may plausibly be perceived as an "overvalued" idea, *see supra* text accompanying notes 273-76, which, like a delusion, American practice defines in part as a belief not "ordinarily accepted by other members of the person's culture or subculture." DSM-III, *supra* note 220, at 356.

282. *See supra* text accompanying notes 88-93.

283. *See supra* text accompanying notes 265-66.

284. Kerbikov & Felinskaia, *supra* note 265, at 411.

285. *See supra* text accompanying notes 88-93.

286. Kerbikov & Felinskaia, *supra* note 265, at 412.

287. In asthenic psychopathy, a "depressed physical condition and a feeling of physical languor are combined with a feeling of personal inadequacy, shyness, extreme vulnerability, and sensitivity." Such patients, "continually dissatisfied with themselves [and] susceptible to depressions," have difficulty adapting to life's routine stresses. *Id.* at 396.

288. *Id.* at 412.

289. *Id.*

sign on Red Square at noon might be described as suffering from an exaggerated sense of her own importance and a chronic "passion for . . . reformist work,"²⁹⁰ yet still be judged "capable of correctly evaluating external reality and governing [her] actions,"²⁹¹ and therefore be held criminally responsible. Or, the depth of her political conviction might be cited as proof of "character alterations . . . so deep"²⁹² as to have inexorably caused her crime, requiring a finding of non-responsibility. There is still a third possibility: the act itself might be invoked tautologically as both evidence and a consequence of "a state of deep decompensation or acute psychopathic reaction,"²⁹³ meriting a finding of non-responsibility. Like a result-oriented judge who selects a few convenient holdings from a body of conflicting case law, the Soviet psychiatrist can make a decision first, then pick a convenient technical incantation. The diagnosis of paranoid psychopathy makes available a potpourri of incongruent formulations with which to articulate the presence or absence of a causal link between illness and act. Whereas a schizophrenic diagnosis in effect subsumes (and decides) the legal question of causation within the issue of mental illness,²⁹⁴ paranoid psychopathy makes causality the key question in the determination of responsibility and gives psychiatrists doctrinal *carte blanche* to decide this question behind formulaic veils.²⁹⁵

C. Forensic Diagnosis and Value Premises

Soviet forensic psychiatrists, in short, follow two evaluative routes toward finding dissenters not criminally responsible. They may invoke a Snezhnevskyan schizophrenic diagnosis, a move which, according to authoritative doctrine, virtually always settles the issue. Alternatively, they may discern a paranoid psychopathy and find a causal link to the proscribed act. For civil commitment, diagnosis per se appears to be less important, owing to the fairly detailed elaboration of mental symptoms contained in the administrative directive that lays out criteria for commitment.²⁹⁶ This directive states explicitly that psychopathic disorders, in themselves, are not sufficient grounds for commitment; and it makes

290. See *supra* text accompanying notes 269-72.

291. Kerbikov & Felinskaia, *supra* note 265, at 411.

292. *Id.* at 396.

293. *Id.* at 412.

294. See *supra* text accompanying note 263; see also *supra* text accompanying notes 88-93.

295. There are no reliable Western estimates of the frequency with which defendants diagnosed as paranoid psychopaths—whether dissident or otherwise—are found criminally non-responsible. The dissenters Vladimir Bukovsky and Semyon Gluzman reported in 1974 that, according to official Serbsky Institute figures, 95.5% of all defendants with this diagnosis were found responsible. But the two intimated that the figure may be lower for dissenters. Bukovsky & Gluzman, *supra* note 145, at 428.

296. See *supra* notes 175-81 and accompanying text.

no mention of schizophrenia, in itself, as a reason for internment.²⁹⁷ Yet the Snezhnevskyan notion that mental processes can, for genetic reasons, be fundamentally and globally aberrant even without "evident psychopathology"²⁹⁸ may underlie the directive's call for "extreme caution" when evaluating persons who display "outwardly correct behavior."²⁹⁹

A particular normative vision of healthy adaptation to life infuses the psychiatric ideas that Soviet clinicians bring to bear upon dissent. From our vantage point, we cannot *prove*, in an empirically compelling way, that such a vision informs all of what Soviet psychiatrists do. Yet we can observe, in an anecdotal way, the implicit value choices they make when they must decide or recommend something, and neither empirical data nor logical inference from data alone is able to provide them with determinative principles.

One systematic example of such a value choice is the leap Soviet psychiatrists make from the schizophrenic spectrum hypothesis to the criminal non-responsibility of virtually all whom they place on that spectrum, whether or not a clinician discerns a relationship between an evident illness and the alleged act.³⁰⁰ Even if the same genetic flaw were biochemically proven present in all persons carrying the diagnosis of a given Snezhnevskyan form—from severely psychotic patients to persons with mild quirks of character—logic alone would not dictate the conclusion that all with this flaw are unable to "realize the significance of [their] actions or control . . . them."³⁰¹ For a person's genotype³⁰² has significance for her ability to cope with life, physiologically and psychologically, only to the extent that it influences her phenotype.³⁰³ In the absence of discerned evidence that an accused's phenotype leaves her less able to "realize the significance of [her] actions or control . . . them," the genotype can be relevant only as a basis for speculation that undiscerned evidence might exist. This possibility is genuine, given the crudeness and uncertainty of psychiatric evaluation. Yet the Soviets' leap from possibility to policy—their general rule, in the face of uncertainty, that persons supposedly on the schizophrenic spectrum have an impaired ability to "control" or "realize the significance of" their actions—is not dictated

297. See Instruction on Hospitalization, *supra* note 162.

298. See *supra* text accompanying note 262.

299. Instruction on Hospitalization, *supra* note 162, at 196.

300. See *supra* text accompanying notes 261-62.

301. See *supra* note 94 and accompanying text.

302. Genotype refers to an organism's genetic endowment.

303. Phenotype refers to the physiologic and anatomic constitution of an organism (a product of interactions among genetic, embryonic, and environmental influences).

by logical inference alone. It is a normative judgment, reflecting commitment to some underlying values. The ambiguous diagnosis of paranoid psychopathy, with its confusing and contradictory mechanistic formulations, also reflects, at bottom, culturally-grounded, normative notions.³⁰⁴

What is the normative vision, or the implicit set of values, that animates Soviet psychiatry's response to dissent? It has been argued that a profound suspicion of any challenge to authority is deeply rooted in Russian mass culture—so much so that, to the average Soviet citizen and the average Soviet psychiatrist, dissenters seem bizarre.³⁰⁵ Historians of Russian culture have observed that the Western-oriented, critically-minded intelligentsia that emerged in the latter part of the nineteenth century felt bitterly alienated from the Russian people.³⁰⁶ Aleksander Blok, a leading Russian poet, wrote in 1909 of “two realities: the people and the intelligentsia; a few hundred million on the one hand, and a few hundred thousand on the other, unable to understand each other in the

304. See *supra* text accompanying notes 265-95.

305. Writing with the well-known dissident Vladimir Bukovsky, Gluzman evokes a normative vision motivating Soviet psychiatry as the “monotonous but tranquil” lifestyle of the “rentier”—a person above all “unwilling to take chances,” with the strongest “instinct for self-preservation.” Convinced that “the higher you fly, the harder you fall,” he “never lets himself get carried away,” and “regards his lifestyle as the only correct one and indeed the wisest and safest one in our existence fraught with adversity.” Bukovsky & Gluzman, *supra* note 145, at 424.

Undoubtedly the dissenter in Soviet life often takes enormous risks, whether in criticizing a policy of the State, too noticeably following a religious faith, attempting to emigrate, or claiming that some personal right has been flouted by the State. To the average Soviet citizen, living in “the land of single file,” see Reich, *The Land of Single File*, *THE WILSON QUARTERLY*, Autumn 1983, at 47, these risks may seem incomprehensible—the product of a maladjusted mind with a contorted sense of reality. Such incomprehension isolates the dissenter from his peers, hiking the hazards of persisting in dissent, and in turn reinforcing its incomprehensibility. To persevere, the dissenter must become even more single-minded, losing friends (and perhaps family), career opportunities, and even physical freedom. Certain emotional reactions are inevitable as a result of this cycle, including fear, suspiciousness, depression, ambivalence, and guilt. See Reich, *supra* note 139, at 34. Thus, when psychiatrically examined by the authorities, the dissenter's embattled commitment to an officially frowned-upon belief or goal may easily seem an obsession, an overvalued idea, or even a delusion. And the dissenter's fears, suspiciousness, ambivalence, and guilt may seem proof of inherent pathology, instead of a normal and understandable response to extraordinary stress.

306. See, e.g., J. BILLINGTON, *THE ICON AND THE AXE: AN INTERPRETATIVE HISTORY OF RUSSIAN CULTURE* 388-90 (1966); Raeff, *Russia's Perception of Her Relations With the West*, in *THE STRUCTURE OF RUSSIAN HISTORY: INTERPRETATIVE ESSAYS* 261 (M. Cherniavsky ed. 1970). Historians have debated whether this estrangement of intellectuals from the masses was something uniquely Russian or whether it had parallels in other societies. Roberts, *Russia and the West: A Comparison and Contrast*, in *id.* at 251.

most fundamental things.”³⁰⁷ The Bolshevik Revolution of 1917 was opposed by most members of the tiny intelligentsia,³⁰⁸ which was decimated by successive Stalinist purges. Thus Soviet bureaucrats and professionals have been products of the anti-intellectual mass tradition. No comprehensive empirical study has explored the attitudes of the average Soviet functionary toward authority and dissent.³⁰⁹ But the mirror image of Russian intellectuals’ estrangement from popular culture and bureaucracy is surely an equally great cultural antipathy toward the intellectuals.

Snezhnevsky’s schizophrenic spectrum model provides a doctrinal tool for the transmutation of such prejudices into diagnosis. Moreover, the general rule that Snezhnevskyan schizophrenics are not criminally responsible, even in the absence of an overt link between illness and act, converts the lack of clinical comprehension of dissenters’ sacrifice and commitment into a wholesale discrediting of the dissenters’ words and deeds. The overlapping and vague concept of paranoid psychopathy more flexibly, if perhaps less credibly, accommodates a clinician’s gut prejudices about a particular case; its supermarket of contradicting formulations offers doctrinal tools for any disposition a clinician, or those with influence over him, might prefer.

The infusion of conventional prejudices about healthy life into psychiatric doctrine is certainly not a uniquely Soviet phenomenon.³¹⁰ Within any culture, conventional lay and psychiatric notions of mental health are likely to reflect an adaptive balance between “daring to live”³¹¹ and knowing “when to stop.”³¹² By our standards, the balance Soviet psychiatrists “enforce” in their interactions with dissenters seems bizarrely askew. But that balance is, at least in part, a plausible product of Soviet ideology and—perhaps even more importantly—classic Russian distrust of pluralistic individualism.

307. Blok, *The People and the Intelligentsia*, in *RUSSIAN INTELLECTUAL HISTORY: AN ANTHOLOGY* 359, 360 (M. Raeff ed. 1966).

308. Monas, *The Revelation of Saint Boris: Russian Literature and Individual Autonomy*, in *THE STRUCTURE OF RUSSIAN HISTORY: INTERPRETATIVE ESSAYS*, *supra* note 306, at 412, 420.

309. *But cf.* M. MEAD, *SOVIET ATTITUDES TOWARD AUTHORITY* (1951) (an empirical study “at a distance,” employing officially published materials).

310. In the most comprehensive longitudinal study of healthy Americans’ adaptation to life’s stresses, the psychiatrist George Vaillant acknowledges at the outset that his “correlatives of healthy adaptation” may seem “confounded with the tenets of Horatio Alger and the Boy Scouts of America.” G. VAILLANT, *supra* note 36, at 17. At the end of the study, he concludes that “[t]he healthy individual is a conservative . . . capable of . . . assessing personal costs.” *Id.* at 374.

311. *Id.* at 370.

312. *Id.* at 367.

V. Implications For International Human Rights Activism

A. *The Current Style of Activism: Confrontation and Castigation*

For most of the active critics of Soviet psychiatry, proof that men and women, mentally healthy by Western standards, have been confined to mental institutions against their will defines a simple problem of good and evil. Certain that psychiatry provides objective standards by which to discern health, disease, and dangerousness, they have mounted a crusade of condemnation against Snezhnevsky and his followers, prosecutors, police, and Party officials for consciously and cynically exploiting psychiatry's potential to discredit and repress dissent. They have cast the dilemma of Soviet psychiatry as a cog in the "Evil Empire" conception of Soviet behavior—as both proof and consequence of the classic post-war conservative vision of aggressive Soviet intentions.³¹³

This approach has animated not only the bulk of the literature on the matter, but also most of Western activism. Exponents of this vision have played the pre-eminent role in shaping the international response, most notably in the two principal international fora that have focused on the issue, the World Psychiatric Association and the United Nations Human Rights Commission.

1. The World Psychiatric Association (WPA)

The WPA, a loose amalgam of national psychiatric societies formed in 1961 to advance international professional exchange, first encountered the issue of Soviet psychiatrists' political role at its 1971 World Congress in Mexico City. Only a few months had passed since the appearance in the West of the firmest evidence yet that Soviet psychiatrists systematically interned dissenters who were sane by Western standards.³¹⁴ In March 1971, a French human rights group had released copies of a number of Soviet psychiatric reports on dissenters obtained by Vladimir Bukovsky. Psychiatrists, convinced that the Bukovsky documents provided compelling evidence of Soviet abuse, attempted to raise the issue in

313. The "devil theory," it seems, is not only popular in the West. See Reich, *Believe It or Not, Half the Soviet People Seem to Believe Americans Are Evil*, L.A. Times, July 12, 1983, § 2, at 5, col. 1.

314. Sporadic reports of forced hospitalization of dissenters had reached the West in the late 1960's. In 1970, the issue began to receive wide attention when noted biologist Zhores Medvedev was psychiatrically interned, Pyotr Grigorenko's description of his psychiatric encounters, see *supra* note 7, was published in the West, and Vladimir Bukovsky recounted his hospital experiences in a CBS television news interview. See S. BLOCH & P. REDDAWAY, *supra* note 5, at 65-78.

Mexico City. However, due to (1) widespread doubts that these documents were so compelling (or even genuine), (2) intimations that the Soviet delegation would walk out if the issue won a spot on the Congress' agenda, and (3) fears that the intrusion of "politics" could jeopardize the organization's scientific mission, the WPA Secretary-General interpreted ambiguous by-law provisions to forestall official airing of the issue.³¹⁵

At the next WPA Congress, however, activists committed to a confrontational, "simple evil" approach won three victories. First, by a narrow margin, over the objections of moderates who urged an exploratory dialogue with Russian psychiatrists, delegates to the 1977 Honolulu Congress voted to condemn the Soviets.³¹⁶ Second, the Congress adopted without opposition³¹⁷ a platitudinous code of ethics. The code provisions bearing on allegations of Soviet abuses illustrate the implausibility of the premise that delineation of the outer boundaries of proper conduct can be accomplished objectively, through world-wide application of "accepted scientific knowledge and ethical principles."³¹⁸

The code proscribes compulsory treatment "unless, because of mental illness, the patient cannot form a judgment as to what is in his or her best interest and without which treatment serious impairment is likely to occur to the patient or others."³¹⁹ This test, ironically, closely tracks the mental illness and causality requirements of the Soviet and A.L.I. criminal responsibility tests,³²⁰ as well as the dangerousness requirements of Soviet and American civil commitment standards.³²¹ The test is thus subject to conflicting value choices, veiled behind different conceptions of

315. *Id.* at 86-93. See also Leigh, *The Psychiatrist and Political Dissidents*, 10 BULL. AM. PSYCHIATRY & L. 227, 228 (1982) (former Secretary-General of the WPA defends his 1971 contention that WPA governing statutes and by-laws did not specifically provide for action against a member society for alleged abuse of psychiatry for political reasons).

316. The resolution of condemnation stated:

That the WPA take note of the abuse of psychiatry for political purposes and that it condemn those practices in all countries in which they occur and call upon the professional organizations of psychiatrists in those countries to renounce and expunge those practices from their countries, and that the WPA implement this Resolution in the first instance in reference to the extensive evidence of the systematic abuse of psychiatry for political purposes in the USSR.

Quoted in S. BLOCH & P. REDDAWAY, *supra* note 2, at 47. A majority of national societies voted against the resolution, including all the Eastern bloc societies, the Scandinavian societies, and a large majority of Third World member societies. But under the WPA's weighted voting scheme (which reflected both the size of each national society and its dues payments), "yes" votes from Western and several Third World members sufficed for a 90 to 88 vote majority. See *id.* at 45-60 (recounting the WPA delegates' consideration and passage of this resolution from the perspective of two delegates who were active in the campaign for a condemnation vote).

317. *Id.* at 48.

318. The Declaration of Hawaii, 1983, *reprinted in id.* at 233, 234.

319. *Id.*

320. See *supra* text accompanying notes 88-94.

321. See *supra* text accompanying notes 174-77.

mental illness, causality, and dangerousness (or “impairment”). Moreover, the code declares:

The psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established.³²²

This proscription is even more obviously studded with unresolved, value-laden problems of definition. Nowhere does the code articulate conceptions of “mental illness,” “causality,” and “impairment”—or of “dignity,” “rights,” and “inappropriate prejudices.” Nor does the code reflect an awareness that such conceptions may vary sharply among cultures, as the Soviet experience suggests.³²³ The fact that both Western and Soviet delegates approved the code is compelling evidence that it begs the key questions of definition.

Third, advocates of the confrontational, “simple evil” line won the delegates’ approval for a resolution creating a committee to investigate cases of alleged abuse.³²⁴ Designed to evaluate individual cases by applying non-Soviet (in fact, Western) principles of practice, this panel was ill-prepared to address two tougher, prior dilemmas: (1) how and why Soviet and Western principles are so different, and (2) the significance of the differences, and the reasons behind them, for the development of international restrictions on the political roles of psychiatry.

Eastern bloc objections and bureaucratic wrangling delayed the start of the committee’s work for more than two years, and the Soviets’ failure to respond to the panel’s requests for materials on alleged cases of abuse thwarted its investigative efforts.³²⁵ For advocates of the confrontational line, the lack of Soviet cooperation along with the arrests that eliminated the Moscow-based Working Commission,³²⁶ became a rallying point for more militant action. The rhetorical response from Soviet psychiatric leaders—continued insistence that interned dissenters were mentally ill by objective diagnostic standards, mixed with accusations that those who questioned Soviet psychiatric ethics were malicious slanderers, cold warriors, and even Zionists³²⁷—hardly strengthened the moderates’ case. By

322. Declaration of Hawaii, *supra* note 318, at 235.

323. The code’s preamble does allude to “great differences in cultural backgrounds, and in legal, social, and economic conditions. . . .” *Id.* at 233. But nowhere does the code acknowledge the possibility that these differences render incoherent the code’s attempt to establish “minimal . . . ethical standards of the psychiatric profession” worldwide. *Id.*

324. S. BLOCH & P. REDDAWAY, *supra* note 2, at 67-71.

325. *Id.* at 111-33.

326. *See supra* note 9.

327. Reich, *supra* note 177, at 22.

the end of 1982, nine WPA member societies from Western nations, representing an estimated 160 out of 315 votes, had approved resolutions calling for action at the 1983 World Congress to oust or suspend the Soviet society.³²⁸ On January 31, 1983, amidst a rising tide of Kremlin hostility toward external critics, the Soviets preempted such a move with their sudden withdrawal from the WPA.³²⁹

Western hardliners in the WPA claimed triumph, restrained only by their regrets that the "enemy" had fallen on his sword, rather than be slain. They voiced hope that their version of Western resolve would engender Soviet feelings of humiliation, prompting high officials to sack Snezhnevsky as they once did Lysenko and to release dissenters from mental hospitals in an effort to regain international respect.³³⁰ But the results so far have been an escalation of vituperative press blasts at critics of Soviet psychiatry,³³¹ a virtual cutoff of dialogue between Soviet and Western psychiatrists, and diminished Western influence in individual cases now that Soviet psychiatrists have little left to lose in the international community. There are no hints either that the position of Snezhnevsky and his deputies is under attack or that psychiatric internments are decreasing.

2. The United Nations Human Rights Commission

Developments in the United Nations Human Rights Commission have been far less dramatic. Yet the approach taken by the United States and by Britain, the principal activists on the issue among the Commission's forty-three member states, has been similarly rooted in a "simple evil" conception of the problem. Prior to 1981, the Commission had not specifically considered charges of political abuse of psychiatry. The closest the Commission had come to the issue was a 1977 vote to charge its Subcommittee on Prevention of Discrimination and Protection of Minorities with the task of developing principles for the protection of

328. S. BLOCH & P. REDDAWAY, *supra* note 2, at 194.

329. See Letter of Resignation from the U.S.S.R.'s All-Union Society of Neuropathologists and Psychiatrists, Jan. 31, 1983, *reprinted in id.* at 249-52 (blaming U.S. State Dep't and American and British member societies for a "slandering," "blatantly political," and "cold war" campaign). The Soviet resignation was followed by Czech and Bulgarian withdrawals a few months later. Cuba resigned at the July 1983 World Congress in Vienna, but other Eastern bloc member societies remained in the organization. See *id.* at 206-14. See also Morozov & Lukacher, *We Condemn This Unseemly Activity*, MEDITSINSKAYA GAZETA, Mar. 25, 1983, *reprinted in* CURRENT DIG. SOV. PRESS, Apr. 27, 1983, at 1 (bitterly attacking Western "slandering campaign" and defending Soviet diagnoses as more than "punishment for non-conformity").

330. S. BLOCH & P. REDDAWAY, *supra* note 2, at 231-32.

331. See, e.g., Morozov & Lukacher, *supra* note 329.

involuntarily committed patients.³³² But in 1981, the Reagan Administration's new U.N. appointees began to use the Commission aggressively as a forum for excoriation of Soviet psychiatric practices.³³³ British delegates supported this effort, albeit adopting a less strident tone.

In the face of strong Eastern bloc opposition, along with Third World antipathy, the Reagan Administration's initiative met with little success.³³⁴ In 1982, the Commission did pass a resolution stating, without naming any particular countries, that "detention of persons in mental institutions on account of their political views or on other non-medical grounds is a violation of their human rights."³³⁵ This language failed to

332. 62 U.N. ESCOR, Supp. (No. 6) at ch. xxi, § A, U.N. Doc. E/5927. After prolonged internal dispute, the Subcommission voted in 1980 to delegate to a Special Rapporteur, Erica-Irene Daes of Greece, the preparation of a set of draft guidelines on involuntary psychiatric detention and treatment. Report of the Sessional Working Group on the Question of Persons Detained on the Grounds of Mental Ill-Health, Subcomm'n on Prevention of Discrimination and Protection of Minorities, U.N. Doc. E/CN.4/Sub.2/1982/17 (1982). Ms. Daes submitted a report on worldwide commitment practices, along with proposed guidelines, to the Sessional Working Group (a panel of experts appointed by the Subcommission to consider the guidelines) in 1982. See E. Daes, Guidelines, Principles, and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorder, Subcommittee on Prevention of Discrimination and Protection of Minorities, U.N. Doc. E/CN.4/Sub.2/1982/16 (1982). But the Working Group has so far been unable to agree on the guidelines, and the process that began in 1977 now appears to have reached a stalemate.

333. In their public statements over the last several years, U.S. representatives have condemned Soviet psychiatric theory as "pseudo-scientific" doctrine, crafted to enable "the Soviet secret police" to regain the Stalinist "power of totally arbitrary arrest and detention." Statement by Richard Schifter, United States Representative (Oct. 28, 1981) (Press Release USUN 88(81) from U.S. Mission to the U.N.) (copy on file with the *Yale Journal of International Law*). Behind the scenes, American delegates have pressed for a Commission vote to condemn the Soviets by name and to create a U.N.-linked panel to investigate cases of alleged abuse. Interviews with officials of the U.S. Dep't of State and U.S. Mission to the U.N., in Washington, D.C. and New York City respectively (1984). The panel, like the WPA review committee, would apply Western standards in considering allegations, without any special focus on the dilemmas of cultural relativity in psychiatric practice.

334. For most Third World members, the "social and economic rights" matter of channeling technology to achieve economic development without disrupting traditional values eclipses psychiatric abuse in significance. Both issues fall within the scope of the Commission's Agenda Item 15—the implications of science and technology for human rights. In their public statements, Third World delegates have tended to mention the psychiatric abuse question only in passing, if at all, while focusing more closely on technology's possibilities for and threats to their respective societies. See, e.g., U.N. Comm'n on Human Rights, Summary Record of the 28th Meeting (First Part), at 14-16, U.N. Doc. E/CN.4/1984/SR.28 (1984) (statement by India); and U.N. Comm'n on Human Rights, Summary Record of the 28th Meeting (Second Part), at 2-3, U.N. Doc. E/CN.4/1984/SR.28/Add.1 (1984) (statement by Congo). Eastern bloc representatives have also given much attention to this latter issue. Thus, there may be at least a tacit alliance between the Soviet bloc and most Third World nations: in return for Soviet bloc support in the social and economic rights sphere, Third World states take a less-than-aggressive stance on the psychiatry issue. Under the WPA's weighted voting system, Third World support was not enough for the Soviets to defeat a condemnation resolution. But within the Commission on Human Rights, a one member/one vote system has made a decisive difference.

335. U.N. Human Rights Commission Resolution 1982/6.

address the possibility that all purported "medical grounds" for detention have a political content, and that the fundamental problem for those concerned with political abuse of psychiatry may be to distinguish between internationally acceptable and intolerable political content. Overall, the confrontational efforts of American delegates to the Commission since 1981 appear to have merely fueled passions without developing insight.³³⁶ It is ironic that this is precisely the criticism Reagan Administration officials have leveled at many Western critics of human rights violations in right-wing states.³³⁷ The ideological selectiveness of recent U.S. government calls for "the light of intellectual insight"³³⁸ in the human rights field hardly enhances the moral force of its U.N. delegates' condemnation of the Soviet psychiatric "evil."

B. *Towards a New Activism*

The international response to Soviet psychiatric internment of dissidents has, in short, been animated by many Western activists' confrontational, "simple evil" conception of the problem. Yet, as this Article has attempted to demonstrate, that conception suffers from fundamental flaws. The KGB and other security organs, it is true, probably find the "psychiatric shunt"³³⁹ a convenient path around post-Stalinist requirements that even crimes of politics and ideology be prosecuted in accordance with "socialist legality." But the practice has much deeper, intertwined roots in Soviet law, psychiatric theory, bureaucratic structure, and culture.

336. The U.S. policy of excoriation without an attempt to analyze and to understand may have only made it easier for Soviet political authorities and psychiatric leaders to dismiss Western criticism as mere cold war propaganda. See, e.g., U.N. Comm'n on Human Rights, Summary Record of the 28th Meeting (First Part), at 8-12, U.N. Doc. E/CN.4/1984/SR.28 (1984) (statement by Soviet Union). On the other hand, Soviet rhetoric has seemed no more oriented toward achieving insight into the vast gulf between Soviet and Western psychiatric practices. In their public statements, Soviet diplomats and psychiatric spokesmen have resolutely insisted that interned dissidents are ill by objective, scientific standards. See *supra* note 329. And when a group of visiting Norwegian psychiatrists queried leading Soviet psychiatrists in 1982 about the possibility that their different conceptions of mental illness could reflect sharp social and political differences, the Soviets brushed aside this line of dialogue. The Norwegians hypothesized three explanations for this—lack of insight into the possibility of diagnostic relativity, conscious self-censorship, and commitment to a biological vision of mental dysfunction. S. BLOCH & P. REDDAWAY, *supra* note 2, at 168-70.

337. The "major shortcoming of far too many human rights groups," Assistant Secretary of State for Human Rights Elliott Abrams wrote, is "an appalling shallowness of analysis. The unique historical, social, and geopolitical conditions of a particular country are often simply ignored. In many cases . . . this intellectual failure is matched by political failure." Abrams, *The Myopia of Human Rights Advocates*, N.Y. Times, Aug. 10, 1984, at A25, col. 1 (criticizing critics of human rights abuses in Turkey).

338. *Id.*

339. See generally M. Field, *supra* note 47.

The Soviet legal test of criminal responsibility invites psychiatrists to veil their value choices about moral accountability behind technical jargon, and Soviet criminal procedure makes it easy for them to do so. Soviet rules for civil commitment make plain the principle that behavior which challenges individuals or institutions in authority is per se a sign of socially dangerous mental disturbance. These rules, when administratively applied without opportunity for judicial or other independent review, provide virtually no means for interned individuals (or their families and friends) to challenge their fates.

Soviet psychiatrists, meanwhile, have developed and applied doctrinal tools that reflect a sense that the dissenter's defiance of authority is incomprehensibly bizarre. With the triumph of Pavlovian theory several decades ago, Soviet psychiatry won wide credibility as a Leninist agent of revolutionary activism and, therefore, a powerful instrument for the sculpting of a new society. The rise of Snezhnevsky's genetic spectrum model of schizophrenia to pre-eminence in the 1960's reflected a dampening of revolutionary hope that crime—including dissent—would wither away. But the theory also squared with the Soviets' persistence concerning the development of socialism. Moreover, the theory's premise of a genetic link between even mild nonconformity and malignant psychosis created an aura of scientific legitimacy around the historically deep-set Russian feeling that nonconformist behavior is something of an anathema. Dissent was a product of genetic disease, not an expression of free moral choice, and psychiatrists were to discharge their forensic duties accordingly.

Were there convincing proof that most Soviet psychiatrists cynically view this psychiatric model as charlatanism in service of repression, yet obediently or actively apply it in conscious disregard for their sensed duties as healers, the "simple evil" theory could not be easily dismissed. But no such evidence has been presented. It is more plausible—though again compelling proof does not exist—that the system of psychiatric belief and behavior that permits the diagnosis and commitment of dissenters is so entrenched *because* it is so credible—scientifically, culturally, and emotionally—to Russian practitioners. For the individual clinician or researcher, this credibility is continually reinforced by the bureaucratic system of incentives, overt and subtle, within which his career unfolds.

The flaws of the "simple evil" theory, however, do not automatically imply that the rhetoric of simple castigation is an improper strategy for activists in the international arena. Conceivably, international moral

condemnation could drive home to Soviet doctors the point that, however genuine their faith in the ethics of the Soviet psychiatric response to dissent, it is reviled by the world community. This sober realization might inspire reassessment of current practice. There is no evidence, though, that any reassessment is under way.

Furthermore, the rhetoric of "simple evil" obscures the reality that many things that trouble us about Soviet practices have problematic analogues in the West. The A.L.I. test of criminal responsibility, commonly applied in this country, closely tracks the Soviet test and similarly invites psychiatrists to veil decisive moral choices behind conclusory labels.³⁴⁰ "Dangerousness" as a criterion for civil commitment is likewise open to Western doctors' politically-laden conceptions of what hazards should be taken into account. Genetic theories akin to Snezhnevsky's are on the rise in the West, with similarly troubling implications for the rights and dignity of those found to have a "hereditary taint." Bureaucratic systems of career training and development nurture in young professionals a cautious reluctance to analyze critically the teachings and prejudices of their superiors. Over time, this reluctance tends to harden into uncritical acceptance. Finally, psychiatric diagnosis and treatment in any society are rooted in homeostatic notions of health as adaptation to external circumstances, and thus tend both to reflect and to conserve dominant values.³⁴¹

If international dialogue on the issue of psychiatry's political role, in the Soviet Union or elsewhere, is to generate illumination, and not merely friction, these component problems need to be explored. We need to understand how, in the peculiar, anti-pluralistic cultural and ideological context of the Soviet Union, the universal vulnerabilities of psychiatry and law have combined to create a political style of clinical practice repugnant to much of the rest of the world. An international dialogue, in vigorous pursuit of this sort of understanding, would have value not only as a precise tool for the identification of what may have gone wrong in the Soviet Union. It could also be a first step toward the development of an international consensus on an irreducible minimum of things mental health professionals ought not to do to people to achieve political ends, whatever the social and cultural context. Even if no such consensus is ever achieved, a continuing international dialogue on the critical political questions at the interface of psychiatry and law in every society would

340. See *supra* text accompanying notes 89-93.

341. See *supra* text accompanying notes 310-12.

raise consciousness on the possibilities for abuse. Achieving such heightened consciousness itself could strengthen the hand of national activists concerned with psychiatry's potential for abuse of individual rights and dignity.

At least one "simple evil" theorist has asserted that any explanation of Soviet practices that acknowledges the possibility of "sincere acceptance" of official psychiatric doctrine "exculpates" the Soviets from charges that they have acted unethically.³⁴² This claim evinces a peculiar conception of ethical responsibility. Surely, explanation need not always require exculpation, for the psychiatrist no less than for the criminal defendants she examines, if we are to preserve the principle of "the responsibility of the doer for his deed."³⁴³ But to preserve this precept in the face of the power of deterministic explanation to rationalize and "justify" every conceivable human brutality, we must formulate and affirm values.

The "simple evil" theorists implicitly do affirm values, under the guise of their claim that Soviet psychiatrists violate objective principles of psychiatric diagnosis and ethics. The idea of objective principles, though, is an oxymoron. All principles reflect underlying values.³⁴⁴ Thus, moral castigation of the Soviets for disregarding "objective" psychiatric "truth" is uninsightful at best and disingenuous at worst. We should openly acknowledge and explore in international dialogue what is culturally relative, conservative, and value-laden about concepts of mental illness, responsibility, and dangerousness. And we should candidly discuss the values underlying our ethical precepts. By so doing, our critique of Soviet practices would be less vulnerable to charges of hypocrisy and therefore more compelling.

342. *See generally* Chodoff, *supra* note 86.

343. *See supra* note 30.

344. *See generally* R. UNGER, KNOWLEDGE AND POLITICS 1-144 (1975).